HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 20, NO. 7, ABSTRACTS 901-1050. JULY 1980

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

See also Abstract Nos. 912, 1003

901. OMAGH. DISTRICT COUNCIL. COMMUNITY WORKING PARTY. **Local acute hospitals in Northern Ireland: the Omagh case examined.** (Chairman: P. Bogan). Omagh, Omagh District Council, [1980]. 75 pp.

In 1979 the Joint Working Party of the Western Health and Social Services Board and the Department of Health and Social Services in Northern Ireland produced a report on the present provision of hospital care and the pattern of services for the future. Its main recommendation was that acute hospital services be based at two centres, Londonderry and Enniskillen, with Tyrone County Hospital as a supporting community hospital. This report sets out the Community Working Party of Omagh District's response to the Joint Working Party's report. They conclude: (i) three acute hospitals are necessary, centred at Derry, Omagh and Enniskillen; (ii) modest increases in staffing levels and improvements in facilities at Tyrone County Hospital in Omagh would not involve large sums of capital expenditure; and (iii) there is sufficient room for such expansion on the Tyrone County site.

902. KING EDWARD'S HOSPITAL FUND FOR LONDON. **The role of the general practitioner hospital in the care of the elderly: report of the conference held at the King's Fund Centre on 6 March 1979.** London, King's Fund Centre, 1979. [i], 13pp. (KFC 79/220)

This conference, held to discuss the role of GP hospitals in the care of the elderly opened with a brief history of GP hospitals in general. Topics discussed include: (i) the consultant's view of geriatric practice; (ii) the GP hospital role in the care of the elderly patient; (iii) co-ordinated community geriatric care from a GP hospital; (iv) the consumer's view; (v) audit and the resource officer; (vi) the nurses' case; (vii) allocating resources; (viii) social services and the care of the elderly sick; (ix) domiciliary support services; and (x) a general discussion on the role, function and administration of GP hospitals.

903. CRISP, Arthur. **In defence of Flowers.** *World Medicine*, London, 1980, May 17, vol. 15, no. 16, pp. 28, 29, 31, 32.

The Flowers working party was set up to consider ways of rationalizing academic medicine in London in the face of growing financial strain. Dentistry and postgraduate schools and institutes were also considered. The working party's proposals include the creation of six pre-clinical schools with an intake of 150 to 250 students and attached to several university hospitals. There have been a number of misconceptions concerning the Flowers report and there are a number of issues which should be considered immediately. There is general agreement that London should remain a centre of medical excellence, but less agreement on how this can be achieved without a huge

capital sum being available. Certain schools who think they are being 'taken over' should remember that, as part of one of six new schools, they will have more influence over the basic course for students and their associated hospitals will remain centres of expanding excellence. Postgraduate institutes could be incorporated but central government financing of their specialist services should continue. Welding together London's resources in the way proposed by the Flowers Report will provide it with a greatly increased academic strength. (See *Hospital Abstracts*, Vol. 20, 1980, Abstract 752).

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 926, 968, 1019

904. LAHTINEN, Y. Sairaaloiden tilastotiedot vuodelta 1978. **[Hospital statistics 1978.]** *Sairaala*, Helsinki, 1979, vol. 42, no. 12, pp. 412-414.

It should be possible to calculate the requirements of a hospital on the basis of comparison with others. Between 1977 and 1978, statistical concepts have been changed, certain information being discontinued because of new ways of classification. The division into central hospital districts appears in many tables, but the information on any district does not refer to that district alone since its institutions also treat patients from other districts. There is a new table of ratios of central hospital districts to population, but here too the figures for 'production' are also approximate. There are great differences between hospitals in ways of classifying working expenditure and capital costs, so the figures are not strictly comparable. Some hospitals only give estimates. There are many figures for cost of services and capacity, the ratios between which can be compared between different institutions, e.g. cost per bed (per day or per patient) and the cost of treating out-patients (per visit). There are wide differences between numbers of out-patients per hospital, and it is not easy to see the real cost of such visits. The figures are comparable only when accounting systems are identical. Statistics will have to contain an estimate of the costs of specialized wards. Whether all hospitals will be able to make estimates of these costs remains to be seen.

905. FULDAUER, A. Ten Kerselaere: een uniek verpleeghuis voor België. **[Ten Kerselaere: a unique type of nursing home in Belgium.]** *Ziekenhuis*, Utrecht, 1979, Nov. 21, vol. 9, no. 22, pp. 562-564.

A unique geriatric centre has been opened in Belgium, a country in which old people with medical and mental disorders are traditionally admitted to general hospitals. The buildings are designed on an open plan, the individual components running into one another. Where partitions are necessary, the walls are mostly glass. Patients' accommodation mostly consists of single rooms, with curtains for privacy. Visiting times are unrestricted, and visitors may accompany patients to physiotherapy, creative therapy or meals. The rehabilitation programme has three phases. The nursing wards have 60 beds for medical patients, and a separate 30 beds for psychiatric cases. The next step, when the condition is improved or stabilized, entails limited nursing care and moving patients to single rooms. Finally there are two small flats, with kitchenette and bathroom for patients about to be discharged home or to old peoples' homes. The centre also functions as a day centre for old people in the district, with meals,

hairdressing, chiropody services, day treatment, and its own bus service. Although patients are not meant to stay permanently, everything possible is done to make them feel at home.

906. HANSON, Lisa. Om sjukhusplanering i u-land. **[Hospital planning in developing countries.]** *Sjukhuset*, Göteborg, 1980, vol. 57, no. 4, pp. 271, 272, 274, 275, 277, 278.

This paper describes, with photographs and some sketch plans, the following hospitals and health care establishments in developing countries: a district hospital in Kenya (with a short account of Kenyan health services); a rural health care centre in Kenya; a hospital at Yanbu, Saudi Arabia; the Mpongwe Mission Hospital, Zambia; and the TB Clinic in São Tome island, off the West Coast of Africa.

907. PETERSDORF, Robert G. **Impact of health care services on medical education in the United States.** *Danish Medical Bulletin*, Copenhagen, 1980, May, vol. 27, supplement 1; pp. 53-57.

The diverse nature of teaching hospitals in the United States, the problems of their financing and the pressures they face are discussed. There has been an astronomical growth in medical education, but there has only been a modest increase in the number and size of university hospitals. The largest single source of new teaching facilities has been in community hospitals. The problems this causes as well as those caused by the pressure to provide community service programmes are discussed. Teaching hospitals must provide a service as well as teach. The balance is now swinging precariously in favour of service. This trend can only be reversed by separating teaching costs from patient care costs and providing better subsidies from the universities, the states or the federal government. The fact that teaching costs are part of doing business is accepted with increasing reluctance. In order to bring service and teaching programmes into equilibrium, a little more money must be spent. It must also be accepted by the public and their elected representatives that medical schools and physicians are a local as well as a national resource, and they must find the means to support this resource.

908. CHRISTIANSEN, Poul M. **Impact of health care services on medical education in Denmark.** *Danish Medical Bulletin*, Copenhagen, 1980, May, vol. 27, supplement 1; pp. 57-60.

In Denmark medical education has been influenced by the government, the universities, the Department of Health, the health services, the local authorities, patients and the Danish Medical Association. The manner in which these influences have developed is outlined. Hospital services have had a great impact on medical education through promoting medical research in hospitals and universities, expanding the medical education system and increasing the standard of hospital care. As a result doctors have preferred careers in hospitals. With the service taking an increasing proportion of the taxpayer's money, political influences have been brought to bear, the major effect being to place a higher priority on primary health care than on hospital care. While the university and its medical education will survive, it might do so with less damage if it arranged for a continuous self-adjustment to social changes.

909. Es, J. C. van. **The role of the hospital in teaching general practice in Holland.** *Journal of the Royal College of General Practitioners*, London, 1980, May, vol. 30, no. 214, pp. 261-266.

This paper is a lecture given by the author at the annual meeting of the North-East London Faculty of the Royal College of General Practitioners. The author describes: (i) the influence of hospital teaching and its relationship to vocational training; (ii) problems of hospital teaching in undergraduate training; and (iii) the contribution of general practice to this training. In Holland, in general, vocational training for general practice is established as six months' hospital training and six months in general practice, which the author considers too short. The long training period in hospital often makes students unsuited for general practice where they will meet a wider variety of patients than in a university hospital. Appropriate teaching of general practice is limited by lack of a teaching tradition and the need for new research methods. In the author's view, effective general practice takes account of the patient's medical life history, his physical, social and psychological aspects, and his relationship with his family. The therapeutic process will, in the last resort, depend upon the relationship between the general practitioner and his patient. Suitable methods of training and research should be developed to take account of these factors.

PLANNING, DESIGN AND CONSTRUCTION

910. Dansk Sygehus Institut. En checkliste til brug ved programmering af sygehusbyggeri. **[A checklist for use in hospital building planning.]** København, Dansk Sygehus Institut, 1979. 44pp. (Notat 001) ISBN 87 7488 1205 Kr.30.00

The Danish Hospital Institute has prepared an annotated checklist to assist non-professional participants in the planning of a hospital construction project. The six sections are: (i) pre-conditions for construction (time, site and financial limits etc.); (ii) intended immediate and future utilization of the hospital; (iii) matters relating to patients, staff and service functions (e.g. supplies, waste disposal), and social functions (e.g. canteens, recreational facilities, child-minding); (iv) departmental divisions and routines; (v) capacity, consumption of materials, staffing establishment and space requirement; and (vi) arrangement, fitting-out and furnishing of each room. A series of nine forms (illustrated) has been developed to assist in planning the immediate and future functions of the hospital.

DETERMINING SIZE OF HOSPITAL AND BED NEEDS

See also Abstract No. 947

911. Banyard, R. and Gorham, M. **Manage . . . be they large or small.** *Health and Social Service Journal*, Basingstoke, 1980, May 23, vol. 90, no. 4694, pp. 679-680.

General hospitals in Great Britain vary in size, largely as a result of historical accident. Since the introduction of the National Health Service there has been a planning trend towards larger general hospitals. However, even before the Bonham

Carter report of 1969, there was already a counter-trend against larger hospitals. Now the government is making strong pronouncements in favour of smaller units and carrying out detailed reviews of all proposed hospitals over 600 beds (800 beds in teaching and regional specialty hospitals). The advantages claimed for larger and for smaller hospitals are listed. Four main factors govern hospital development: existing facilities (both quantity and quality); available sites; perceived requirements, present and future; and availability of capital and revenue finance. It is unrealistic to divorce any of these factors from each other. Further, size cannot be measured by bed numbers alone, but must take into consideration the physical environment and complexity. The essential problem is not to find the optimum size or to establish a universally perfect structure; rather it is to provide appropriate management for all hospitals large and small.

912. HALPERN, Stephen. **Sizing up the size problem.** *Health and Social Service Journal*, Basingstoke, 1980, June 6, vol. 90, no. 4696, pp. 730, 731.

The Department of Health and Social Security (DHSS) consultation paper 'Hospital Services—the Future Pattern of Hospital Provision in England', (see *Hospital Abstracts*, Vol. 20, 1980, Abstract 754) sets out broad guidelines for future building programmes and discusses the implementation of a policy for smaller hospitals. The paper compares the advantages of large and small hospitals. While communications management may be difficult in a large hospital, in the small hospital relations with the local community and the primary care sector are easier. Larger hospitals in urban areas would be the 'main' hospital with 450 to 600 beds depending on the size of the catchment population. This hospital would include an accident and emergency department, associated medical and surgical services, the majority of maternity beds, a children's unit and 30 per cent of geriatric beds. Other bed requirements would be met in smaller hospitals. A new type of facility, the nursing home, is also being considered, and the closing of some 30 large psychiatric hospitals is envisaged. However, the DHSS has approved the majority of current building schemes and suggests that the nucleus hospital can be used in the new policy. The new scheme will necessitate changes in many areas of the National Health Service. There will be medical staffing problems and smaller hospitals will limit the scope for deployment and training of staff.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

913. GANDEE, Charles K. **A major new health care facility for Detroit: an efficient machine designed with compassion.** *Architectural Record*, Hightstown, N.J., 1980, April, vol. 167, no. 4, pp. 83-90.

The 340-bed Detroit Receiving Hospital and the Wayne State University Health Care Institute, an out-patient clinic/teaching facility, occupy the same site and are connected on the first three levels. The two buildings cost $125 million and encompass almost 900,000 square feet. To relieve the bulk of so vast a structure, a cruciform pattern was adopted. The buildings are constructed around six 48-feet square atriums with space pods branching out from each corner, and four vertical shafts. The

courtyard plan allows the building to be lower and still have maximum lighting perimeter. Patient rooms are placed along the exterior walls of the individual clusters, to open views to the outdoors. Plans and photographs are included.

EXTENSIONS AND RECONSTRUCTIONS

See also Abstract No. 919

914. ALM, Eric. Örnsköldsviks sjukhus—ett sjukhus i förnyelse. **[Örnsköldsvik Hospital—a hospital in the process of regeneration.]** *Sjukhuset*, Göteborg, 1980, vol. 57, no. 4, pp. 229, 231, 232, 234, 236.

The main block of Örnsköldsvik Hospital, built in 1949, has had to be extended to meet modern requirements. The hospital complex now consists of the following buildings: the old hospital, used for long-stay patients; the main block, with five wings; the infectious diseases block; mortuary; boiler house; and the kitchens. There is an underground car park and separate subways for clean and dirty materials linking the buildings. The paper is illustrated with a site plan and two photographs.

DESIGN OF SPECIAL DEPARTMENTS

915. BJURSTRÖM, Frederik. Akademiska sjukhusets nya barnklinik-byggnad. **[The new paediatric unit at the Academic Hospital, Uppsala.]** *Sjukhuset*, Göteborg, 1980, vol. 57, no. 4, pp. 187, 188, 193, 194, 197, 198.

The new children's block at the Uppsala teaching hospital, completed in August 1979, is part of Phase Four of the hospital: the other part of Phase Four is the women's block which is scheduled for completion in 1984. The 102 beds are allocated as follows: medicine, two wards each of 18 beds; surgery, one ward of 26 beds; intensive care, 18 beds; neonatal, 20 beds; metabolic unit, 2 beds. Wards are on a double corridor plan with single, double and four-bedded patient rooms. The paper includes a site plan, floor plans and eight photographs.

WARDS AND PATIENTS' ROOMS

See Abstract No. 971

ENGINEERING SERVICES

COMMUNICATION SYSTEMS

See Abstract No. 1033

HEATING

See also Abstract No. 917

916. BROCKMEYER, H. Neue VDI-Richtlinie über Wärmerückgewinnung. **[The new heat recovery guidelines of the Association of German Engineers (VDI).]** *Krankenhaus-Umschau*, Kulmbach, 1980, April, vol. 49, no. 4, pp. 276, 277.

The new heat recovery guidelines prepared by the Verband Deutscher Ingenieure (VDI—Association of German Engineers) have appeared in two parts. Part 1 (Terms and technical descriptions) was published in August 1978 and Part 2 (Efficiency calculations) in June 1979. The main features are described here with particular reference to heat recovery in hospitals. The guidelines aim to achieve uniformity of definitions and calculation procedures so that an optimal solution, from the point of view of energy technology, can be worked out under defined conditions. A heat recovery unit alone is not, however, a guarantee of an efficient solution to the whole problem. The structural design and the concept of the ventilation installations are important parameters for an optimal solution.

ENERGY CONSERVATION

See also Abstract No. 916

917. ARMSTRONG, J. H. **Aerial heat loss survey of hospitals.** *Hospital Engineering*, London, 1980, May, vol. 34, no. 4, pp. 14-16.

Surveys of aerial heat loss using infra-red photography were carried out on 100 hospital sites in the West Midlands Regional Health Authority. An infra-red survey provides a picture of the ground, indicating the relative temperature variation of the surface features. The equipment used consists principally of a thermal line scanner, the operation of which is described. Radiation received is transformed into an electrical sign and recorded on magnetic tape. The data is played back via a cathode ray tube and exposed on film to produce a number of images for interpretation. The survey firm provides an analysis of these thermal images together with a written report and a site plan showing the main areas of heat loss. Area works officers have found the results very useful since they identify both the location of heat loss areas and their degree when compared with the rest of the site. This shows quickly where remedial work is needed and can be used for preparing an insulation and energy saving programme. The cost of the survey was approximately £600 per site which the Region expects to recover in the annual energy bill within 12 months.

918. KEEFOVER, Marvin D. and MCVAY, Bruce. **Hospitals lead the way in energy conservation.** *Consulting Engineer*, Barrington, Ill., 1980, April, vol. 54, no. 4, pp. 116-121.

At first glance, hospitals might seem unlikely candidates for drastic energy conservation measures, since they are exempt from energy conservation laws, would be given priority if fuel supplies had to be allocated, and have to meet stringent codes on mechanical and electrical design. Nevertheless, they are playing a leading role,

because they are part of a high technology industry, are used to constantly changing functional requirements, and are large energy users offering great potential for savings. Using a number of United States hospitals as examples, this paper examines the means by which energy savings are being achieved through design, heat recovery systems, energy-saving lighting systems, adequate controls, and power distribution design.

INSULATION AGAINST SOUND AND TEMPERATURE

See Abstract No. 917

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 921

919. INSTITUTE OF BUILDING. HOSPITAL BUILDING COMMITTEE. **Rehabilitation, maintenance and materials technology: a two day conference mounted by the Hospital Building Committee of the IOB at the Scottish Health Service Centre, Edinburgh, on 10/11 October 1979.** Ascot, Institute of Building, [1979]. Various pagination. £3.00

In connection with a conference on reconstruction and maintenance of hospitals a folder has been issued with copies of the eight papers presented. Some of the papers are as follows: (i) rehabilitation of existing premises; (ii) timber treatment; (iii) interior design; (iv) drainage problems; (v) the case for prefabricated building; and (vi) decoration as a maintenance problem. The other papers deal with fire safety considerations and planned preventive maintenance.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

See Abstract No. 995

EQUIPMENT GENERALLY

920. ENGLAND, Roger, compiler. **How to make basic hospital equipment.** London, Intermediate Technology Publications, 1979. 86pp. ISBN 0 903031 60 4 £2.95

This book provides some simple designs which could help to provide solutions to the problems of equipping rural hospitals using local skills and local resources and materials. In developing countries costs can be reduced considerably whilst still providing adequate equipment. Many of the designs for beds, trolleys, wheelchairs and other equipment have been used in Africa and can be made from wood, metal tubing and wheels taken from scrap heaps.

MEDICAL EQUIPMENT

921. VANDERSOUPEL, M. La maintenance du matériel médical. **[Maintenance of medical equipment.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, Jan., no. 192, pp. 45-49.

The author suggests that, for the purpose of maintenance, medical equipment should be divided into equipment which comes into contact with the patient (respirators, monitors, defibrillators) and that which does not (medical fluid units, ambulances, emergency generators). The two categories overlap because a respirator cannot reach the patient if the ambulance has broken down. Maintenance must therefore be planned with regard to the relationship between the different categories of equipment and the different teams (vehicle maintenance staff, biomedical equipment maintenance staff, and medical and nursing staff), and it must be sympathetic and preventive. The author discusses the advantages and disadvantages of after-sales service contracts; he feels that they are essential for large items such as lifts, scanners, and linear accelerators. After proper training the hospital's own staff should be able to cope with most other equipment. Staff need plans and diagrams of the equipment, stocks of spares, and the correct tools, and they should keep records of work done. The technicians responsible for maintenance should be consulted whenever new equipment is being chosen.

TROLLEYS, STRETCHERS, ETC.

See Abstract No. 1015

STAFF GENERALLY

See Abstract Nos. 1037, 1050

STAFF COMPLEMENTS

See also Abstract Nos. 938, 1001, 1013

922. TELFORD, W. A. **A manpower information system.** Birmingham, The Author, at East Birmingham Health District, 1980. [v], 25pp.

Manpower planning in practical terms relies heavily on manpower data collection and processing. This pamphlet demonstrates one approach to manpower information. It shows the basic documentation form, the computer coding form and a series of standard reports taken from the data base.

RECRUITMENT

See Abstract No. 1009

STAFF MANAGEMENT

See also Abstract No. 1006

923. METZGER, Norman. **Personnel administration in the health services industry.** 2nd edition. New York, London, SP Medical and Scientific, 1979. [vii], 299pp. ISBN 0 89335 074 5 £12.50

Good staff management is as important as medical equipment or drugs for the efficient running of a hospital. Basic information is given on job analysis, wage bargaining and staff training. In addition to updating information from the first edition, this volume covers union organization and preventive labour relations. New chapters have also been added on grievance and arbitration procedures, and questions attendant on contract administration.

924. ZERUBAVEL, Eviatar. **Patterns of time in hospital life.** Chicago, Ill., London, University of Chicago Press, 1979. xxiv, 157pp. bibliog. ISBN 0 226 98160 6 £9.45

This book presents a study in the sociology of time based on the author's observation of the activities of medical professionals in a large teaching hospital. From the data collected it can be shown that while individuals customarily adapt to a variety of contexts for anchoring events in time, the temporal co-ordination necessary for collective effort enforces social control at many levels. Topics discussed include: (i) the rhythmic structure of social life; (ii) the temporal structure of responsibility; (iii) the temporal division of labour; (iv) sociotemporal reference frameworks; and (v) the sociotemporal order. A bibliography is included.

STAFF RELATIONS

See also Abstract No. 953

925. GARRIGUE-GUYONNAUD, H. L'information du personnel de l'hôpital. **[Staff communication in the hospital.]** *Gestions Hospitalières*, Mantes-La-Jolie, 1980, Feb., no. 193, pp. 161-164.

It is important from both staff and management points of view that staff should be kept informed of events and changes in the hospital. The author profers practical advice on the provision of information. General information should be circulated to all staff; information on work or careers only to those directly concerned. Clear and direct language, and short sentences in everyday language, should be used. Management teams should receive some training in communication and time should be taken to introduce every new member of staff to the organization and aims of the hospital. The author also recommends the establishment of multi-disciplinary *ad hoc* working parties on specific topics, the encouragement of lateral flows of information, the presentation of monthly information reports by line management, and the establishment of readily available files on a series of topics such as legislation or organization.

STAFF TRAINING

See also Abstract No. 908

926. DAVIS, David A. **Promoting education in a community hospital.** *Dimensions in Health Service*, Ottawa, Ont., 1980, March, vol. 57, no. 3, pp. 38-40.

Although continuing education is not often considered necessary in non-teaching community hospitals, the Joseph Brant Memorial Hospital, Burlington, Ontario, formed an Interprofessional Education Council from professional and paramedical groups to deal with an obvious need. Sub-groups included an executive committee, a programmes and priorities committee, and a library and audio-visual committee. Three other committees dealt with the educational needs of medical and nursing staff and with interprofessional programming. All educational activities, both existing ones and those requested by staff, were reviewed by the programming committee. Evaluation of the system led to some changes in the structure of the Council. The format followed at the Joseph Brant Memorial Hospital may be applied to other community hospital education programmes. The model requires a steering committee to co-ordinate educational activity, while another assesses the needs. It is evident that continuing education in a community hospital is vital to the delivery of good health care.

STAFF WELFARE

See also Abstract Nos. 951, 999

927. TELFORD, W. A. **'Time Out': a matter for management.** Birmingham, The Author, at East Birmingham Health District, [1980]. [57]pp.

This report gives details of a management information system for nurse sickness and absenteeism. It began as a manual system covering five basic elements: (i) annual leave; (ii) Bank holidays; (iii) sickness; (iv) absence; and (v) study leave. This proved very time consuming and its benefits were of minimal application. Consequently a commercial computer agency was brought in to provide the hardware, training and support needed for programming. Time saved has meant an enlargement of the system to provide more alternatives for 'time-out'. As a planning tool this new system has proved very useful, policies on sickness have been reviewed and managers given new guidelines. Within divisions, information is being used to monitor units. The system fails when brought to ward level and has proved uneconomic, but has potential in estimating the replacement cost of 'time out' and the real cost in terms of money.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

928. MARSTON, P. **The management of geriatric orthopaedic patients.** *Demonstration Centres in Rehabilitation Newsletter*, Middlesbrough, 1980, April, no. 20, pp. 6-11.

In the early 1970s the Hasting Orthopaedic Centre became a demonstration centre for the rehabilitation of geriatric orthopaedic patients. Because of the widened role of

the centre, the consultant in charge decided to use part of the money available to provide a unit manager to co-ordinate the day-to-day running of the centre. A job description was drawn up for a manager in the general administrative grade and responsible to the senior consultant. The manager's role is really a clinical one—to make sure that the patient benefits by the proper organization of the unit. It includes: co-ordinating all arrangements to be made on behalf of the patient at the pre-admission assessment clinic; determining the best time for the patient's admission; organizing admissions; liaison between hospital and community; and administrative functions, including training and supervision of the centre's secretarial staff.

MEDICAL STAFF

See also Abstract Nos. 908, 1033

929. GRANTHAM, Harry. Le pouvoir de décision du médecin dans le centre hospitalier: de l'exercice quotidien au temps de crise sociale. **[Decision-making powers of hospital doctors: a daily exercise at a time of crisis.]** *Administration Hospitalière et Sociale*, Montreal, Que., 1980, Jan./Feb., vol. 16, no. 1, pp. 25, 26, 28-30.

The author examines the duties, responsibilities, and powers of the hospital doctor in a rapidly changing society. The hospital must provide conditions in which the doctor can practice medicine of a high quality. At institutional level the doctor, represented by the medical committee, must be allowed to participate in administrative policies and be consulted as to the choice of objectives, programmes and the allocation of resources. In times of crisis, such as during strikes, only the doctor is in a position to judge whether a particular patient requires urgent treatment or not. The author suggests that objective pilot studies should be carried out during a crisis to evaluate whether the population does actually suffer; it might then be possible to establish clinical criteria for priority treatment as a function of acceptable waiting time.

NURSING STAFF

See also Abstract Nos. 927, 992, 995, 1048

930. CHANCE, Helen C. and HINSHAW, Ada Sue. **Strategies for initiating a research program.** *Journal of Nursing Administration*, Wakefield, Mass., 1980, March, vol. 10, no. 3, pp. 32-39.

A hospital based nursing research programme should improve patient care by producing data critical to administrative and clinical decisions. This paper describes the strategies used to establish and legitimate such a programme at the 300 bed University Hospital, Arizona Health Services Center. Three critical factors facilitated the initiation of the programme: the research oriented attitude of the nursing administrator; the existence of a research environment in the nursing department; and the values and flexibility of both the hospital and the nursing department organizational structure. Formalizing the research section involved establishing posts, recruiting nurse researchers, establishing aims and objectives, and determining the types of

research programmes to be conducted. Once the research section was established, it was incorporated into the structure of the nursing department: to establish clear, formal responsibility, accountability and communication; to establish feedback channels for research information and to determine sources of funding for projects. Once the section had been firmly established, research activities gained momentum of their own accord.

931. GRYPDONCK, M. Eigenschappen van verpleegkundigen en staffing van verpleegeenheden. **[Nursing qualities and the staffing of nursing units.]** *Hospitalia*, Brussel, 1979, vol. 23, no. 3, pp. 148-152.

In integrated nursing, patient allocation is a central concept, total responsibility for care being placed on individual nurses. The ward sister must strive for optimal compatibility between the needs of the patient and the qualities and capabilities of the nurse. The difficulty of a task is not determined by the task itself but by the patient for on whom the task is carried out. The non-medical aspects of nursing are now better understood; the nurse must be conscious of the way in which the patient experiences the nursing treatment given. Planning, carrying out and evaluation of treatment are closely interlinked. A differentiated utilization of nurses, taking their individual and specific capabilities into account, is desirable and feasible, not only for the good of the patient but also for the job satisfaction of the staff. A nurse who is not good at certain tasks or who is afraid of, for example, nursing terminal patients, could be teamed with one who is particularly good at this, and thus overcome her fears by learning from the other. By making a 'profile portrait' of the staff of a nursing unit it should be possible to suit the needs of different categories of wards and patients. The ward sister should know what demands to make on any new member of the team.

932. LELEAN, Sylvia. **Nursing research in the United Kingdom excluding Scotland.** In: NATIONAL ORGANIZATION OF PROFESSIONAL HEALTH WORKERS. Collaborative research and its implementation in nursing: first conference European nurse researchers. Utrecht, National Hospital Institute, 1979, pp. 69-73.

This paper discusses the current state of nursing research in the United Kingdom. The development of interest in research in nursing within the Health Departments and National Health Service, largely fostered by the Royal College of Nursing of the United Kingdom (RCN) is discussed. Topics considered include: (i) the need for nurses to be educated in research; (ii) the dissemination and use of research findings; (iii) the development of resource centres; and (iv) the role played by professional organizations.

933. MCFARLANE, Jean Kennedy, Baroness McFarlane of Llandaff. **Essays on nursing.** London, King's Fund Centre, 1980. 60pp. (Project Paper No. RC2) £1.00

This is a collection of papers written for the Royal Commission on the National Health Service. The topics comprise: (i) the role of the nurse; (ii) clinical career structure; (iii) alternative career structures; (iv) nursing education and research; and (v) the quantity of nursing care. Each paper is set out in clear sections (e.g. nursing manpower, nurse teachers) and concludes with a list of references.

934. MacGuire, Jillian M. **The expanded role of the nurse.** London, King's Fund Centre, 1980. 74pp. bibliog. (Project Paper No. RC3) £1.00

In recent years, the concept of the expanded role of the nurse has provided considerable discussion amongst the medical, nursing and administrative professions. This paper explores and documents the large body of literature covering this area and includes a bibliography of British and American sources. Issues surrounding the acceptability of the 'nurse practitioner', the characteristics of her role, the evaluation of care provided, and cost considerations are discussed.

935. Münster, P. and Seid, B. Der Leistungsbegriff im Krankenhaus—Theoretische Grundlagen und Anwendungen in einem Leistungskatalog für den Pflegebereich. **[The concept of performance in the hospital: its theoretical basis and its use in a list of nursing activities.]** *Krankenhaus-Umschau*, Kulmbach, 1980, April, vol. 49, no. 4, pp. 262-264, 273-275.

The theoretical aspects of 'hospital activities' are discussed in some detail and a number of definitions of the term are compared. To give a concrete example, a comprehensive list of nursing activities is presented, divided up under the following heads: care of the patient on admission; care of the in-patient; care of the patient on discharge; help with basic needs; help with basic needs bearing in mind the personal situation of the patient and the state of his illness; patient observation; helping with the patient's treatment; teaching, training and research activities; and administrative activities.

936. National Organization of Professional Healthworkers in the Netherlands and National Hospital Institute (Netherlands). **Collaborative research and its implementation in nursing: first conference European nurse researchers.** Utrecht, National Hospital Institute, 1979. 147pp. bibliogs. Sw.Fr.12.00

The current importance of research into all facets of nursing was considered in this nursing conference held in Utrecht in 1979. The main aspects of nursing research were considered from the viewpoints of its current state of development in European countries, including the United Kingdom; collaboration in research; and the definition of nursing research. A list of conference participants, the conference programme, and annexes covering abbreviations, definitions of terminology, a questionnaire on nursing research and collaborative research and its implications in nursing are also included.

937. Orlow, Gabriele. Arbeitsplatzbeschreibung einer Dialyseschwester. **[The work of a dialysis nurse.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1980, June 1, vol. 33, no. 6, pp. 317-325.

The nurse's basic training is not sufficient for a dialysis nurse and post-basic specialist training is necessary. In some of the *Länder* of West Germany a two-year part-time training is possible, followed by examination and certification. An outline is given of the theoretical basis and practical application of dialysis nursing techniques, including a list of subjects to be included in the training course. The areas of work of the dialysis nurse are discussed under the following main headings: home dialysis; limited care dialysis; and hospital dialysis. A detailed list of duties for a nurse in a hospital dialysis unit is set out hour by hour for a period of duty from 6 am to 2 pm.

938. TELFORD, W. A. **A method of determining nursing establishments.** [Birmingham], The Author, at East Birmingham Health District, 1979. [ii], 20pp.

There are many methods for the important function of determining nursing establishments, this one has been used in the West Midlands Region of England. As well as being useful for new establishments, this method can be used as a tool to redeploy existing staff. Comparisons are made with other methods in terms of ease of application and professional acceptability.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See Abstract No. 1009

939. COUNCIL FOR PROFESSIONS SUPPLEMENTARY TO MEDICINE. WORKING PARTY ON THE FUTURE. **PSM registration and self regulation: future requirements and opportunities.** (Chairman: Sir Norman Lindop). London, Council for Professions Supplementary to Medicine, 1980. iv, 38pp. bibliog.

The Council for Professions Supplementary to Medicine set up a Working Party in an attempt to establish more clearly the opportunities and requirements of professional self-regulation. One major finding emphasized the federal nature of the organization which brings together professions widely different, each being an autonomous organization with its own character, needs and policies. Consequently, the Working Party had difficulty in defining the area of agreement between the professions as represented by their institution and registration boards. The Council has concluded that such is the urgency for development in professional education and training, and such is the absence of concensus on the extent and character of organizational change to achieve it, that the independent inquiry into PSM manpower, training and registration recommended by the Royal Commission on the NHS is urgently required.

ANCILLARY STAFF

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 997, 1032, 1046

940. AGERSNAP, Torben. Sygehusets organisation år 2000. **[Hospital organization in the year 2000.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 4, pp. 19, 22.

The author speculates on whether the very large hospitals of today, with their many specialties, will continue to exist after the year 2000, or whether they will be replaced by smaller, decentralized units with more treatment available to the patient in his own home. Technology is an essential part of the large hospital and it is difficult to know whether we should allow the technical expert to decide whether the present system should continue or whether the customer (i.e. the patient) should decide which system is preferable. In a large modern hospital the in-patients are generally far away from their own homes and families which is a form of discrimination against them. The

proliferation of high-technology health care has not led to the disappearance of disease, and the author suggests that smaller, simpler units could be better.

941. FRISVOLD, Odd J. Ulike administrasjonsordninger i sykehus. **[Differing administrative arrangements in hospitals.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 4, pp. 3-6, 8.

A general discussion is presented of the different types of administrative structures in modern hospitals. The customary alternatives are to have professional managers in the central administration, with considerable bureaucratic control over professional and economic activities in every department, or a system of strict professional and economic responsibility in the individual department. The author proposes a third alternative—the presence of medical as well as professional managers in the central administration. It is argued that, since the main purpose of the hospital is medical and technical, direct medical involvement and influence at the centre are necessary.

942. GREVE, W. B. de. Professie en management in de organisatiestructuur van het ziekenhuis. **[The specialties and the hospital management structure.]** *Ziekenhuis*, Utrecht, 1979, Dec. 19, vol. 9, no. 24, pp. 646-648.

Eight organization structures are considered and in particular the Swedish 'block' model. The block structure differs from the others by encompassing the total hospital organization; integration and decision-making are thus more comprehensive. The 739-bed Catharina Hospital in Eindhoven is divided organizationally into six blocks: internal specialties (218 beds; 167 staff); therapeutic specialties (218 beds; 144 staff); children and women's services (206 beds; 122 staff); psychology and neurology (99 beds; 57 staff); out-patient services (286 staff) and casualty services (107 staff). Each block is directed by a senior man working downward through a block council and upward to the hospital directorate via the heads of block committees. There are two diagrams of organizational patterns.

GOVERNING BODIES, COMMITTEES

943. UMBDENSTOCK, Richard J. **Governance: a decade of steady growth.** *Trustee*, Chicago, Ill., 1980, April, vol. 33, no. 4, pp. 17-19.

A review of the literature on hospital governing boards in the United States of America in the 1970's shows that hospital trustees are playing a more active role in the control and direction of the modern hospital. Attention was paid to successful board performance through strong leadership and an effective committee structure. The board's relationship with medical staff continued to receive close attention, emphasis being placed on the board's responsibility for ensuring that medical staff were pursuing their proper functions. The importance of informed communication between the hospital board and hospital management was also stressed. Trustee conferences and educational schemes for board members increased during the 1970's. Boards were encouraged to take part in plans for cost containment and to consider carefully any major changes in the hospital, such as joining a multi-hospital system. This current emphasis on effective performance shows how seriously trustees view their service on a hospital board.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 969, 977, 1005, 1008

944. L'opération sauvetage de la clinique Bizet. **[A salvage operation for the Bizet Clinic.]** *Argus des Collectivités*, Paris, 1980, May, no. 318, pp. 9-12.

This is an account of the virtual rebuilding of the Bizet Clinic in Paris. The entire operation was organized by Co.Te.Ba. (Technical Construction Co-ordination Company), a company formed in 1961 for the purpose of offering an original and efficient operational structure for the management of construction projects. This company planned the operation, obtained tenders, appointed builders, selected specialist equipment, supervized a workforce of 200, and were responsible for the financial management of the project. Computers were used at every stage of planning. The entire operation took 14 months. The clinic now has 109 beds for surgery and 30 for cardiology. There are 86 patients' rooms, 12 of which are used for intensive care. The clinic is fully equipped with modern diagnostic equipment. A unique feature is that five of the 11 floors are below ground.

945. SHAW, Charles D. **Aspects of audit: 4. Acceptability of audit.** *British Medical Journal*, London, 1980, June 14, vol. 280, pp. 1443-1446.

Arguments about how acceptable and workable medical audit is in Britain are based as much on conjecture as on practical evidence, owing both to lack of experience in Britain and to the natural fertility of folklore. Moreover, because of the many different meanings ascribed to audit and the various methods, generalizations cannot usefully be made. The debate on the acceptability of audit focuses on three questions: how is it controlled?; what does it cost?; and does it work? The objectives of audit have been defined as education, planning, evaluation, research, and anticipatory diplomacy—that is, starting internal audit before external audit is imposed on the medical profession. Published reports suggest that in Britain internal audit would be more effective and less expensive than the complex professional standards review organization devised by the federal government in the United States. A list of 77 references to the literature is included.

946. SHAW, Charles D. **Aspects of audit: 2. Audit in British hospitals.** *British Medical Journal*, London, 1980, May 31, vol. 280, no. 6227, pp. 1314-1316.

Despite the fact that they handle a relatively small and selective proportion of the work load in health care compared with long-stay care, general practice and community health, acute hospitals appear to be the ideal places to evaluate and develop medical audit in Britain for several reasons: more uniform and comprehensive medical records, statistical and diagnostic data; fewer patient contacts; and more time to examine patients and record information. Although little has been published, a few studies show the extent to which formal audit has been developed in Britain. Brief details are given of the aim, method, findings and conclusions of nine studies covering hospital procedures and units, clinical management, and referrals from general practice. There are many questions about what kinds of audit are workable in Britain. The experience from overseas may answer some, but many require experimentation and publication of the conclusions. There is no better testing ground than the hospitals.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 963, 972, 1041

947. CULLIS, J. G., FORSTER, D. P. and FROST, C. E. B. **The demand for inpatient treatment: some recent evidence.** *Applied Economics*, London, 1980, March, vol. 12, no. 1, pp. 43-60.

Feldstein (see *Hospital Abstracts*, Vol. 5, 1965, Abstracts 219, 772, 999, 1717, 1802) showed that a substantial proportion of inter-regional variation in the demand for in-patient treatment can be explained by differences in the availability of hospital beds. His conclusions are examined in the light of 1975 data for the English regional health authorities. In addition, one region, Trent, was selected to examine the same relationships at district level. This analysis confirms that the demand for in-patient treatment is strongly related to the availability of beds, and shows that it is possible to better Feldstein's results. It is also shown that the mortality experience of an area is not significantly related to hospital admissions, bed use or bed provision. It is widely expected that implementation of the recommendations of the Resource Allocation Working Party (RAWP) will have a dramatic effect on the distribution of hospital resources. This study suggests that the use, age and sex indicators rather than mortality alone (as recommended by RAWP) might be a step in the right direction for a National Health Service which provides hospital care.

948. HERSEY, F. and O'NEILL, P. **Reducing post-operative hospital stays.** *Dimensions in Health Service*, Ottawa, Ont., 1980, March, vol. 57, no. 3, pp. 22, 23.

The authors carried out a study which investigated two factors influencing post-operative stay: (i) the amount of choice the patient felt he had over whether or not to have the operation; and (ii) the amount of information the patient was given about his condition and his operation. The study group consisted of 100 adult patients admitted to a regional hospital in Nova Scotia over a six-month period for scheduled major surgery. The study was conducted by the nurse responsible for obtaining consent to surgery from patients. The patients were asked to describe the nature and urgency of their operation. The comments of the patients were rated to determine: (i) the amount of accurate information received; and (ii) the amount of choice offered. Better understanding of the operation did not result in a shorter post-operative stay, but there was a definite link between perceived choice and post-operative adjustment, resulting in earlier discharge.

949. ROYAL INSTITUTE OF PUBLIC ADMINISTRATION. HEALTH OPERATIONAL RESEARCH UNIT. **Planning future bed requirements.** Reading, Royal Institute of Public Administration, Health Operational Research Unit, [1980]. [4]pp. (Broadsheet No. 7)

Planners need to answer the following questions: (i) how many acute beds are needed in total; (ii) how should beds be allocated between specialties; and (iii) where should the beds be located? A comparative approach is recommended, using differences in provision between specialties and between areas. Targets can then be decided taking into account expected population change, and trends in discharges or deaths; equations used in a trial study are detailed.

950. WEYERER, S. and DILLING, H. Der Einfluss der sozialen Schicht auf Aufenthaltsdauer und Entlassung. **[The influence of social class on duration of hospital stay and discharge rate.]** *Social Psychiatry*, Berlin, 1980, vol. 15, no. 2, pp. 95-101.

In an investigation in 1971 based on the regional psychiatric hospital at Gabersee in South-East Bavaria, the duration of stay of patients was found to be inversely related to their social class. The lower the social class, the higher the proportion of patients in hospital for more than two years. The proportion of patients discharged within four years of admission was higher among those from the upper and middle classes. These findings were comparable to an American study carried out in 1968. It was noted that the influence of social class on prognosis for hospital discharge diminished with increasing length of stay.

OFFICE MANAGEMENT AND METHODS

See also Abstract Nos. 922, 927

951. SØRENSEN, K. H. Arbeidsmiljø på sykehuskontor: en undersøkelse av arbeidsmiljø for kontoransatte ved Regionsykehuset i Tromsø. **[The hospital office environment: a working environment study of staff conditions at the Tromsø Regional Hospital.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 1/2, pp. 31, 32, 34, 35.

Copies of a questionnaire were distributed to hospital office staff on: (i) conditions and times of service; (ii) work loading, including the physical environment; (iii) co-operation and the social environment; (iv) stress; (v) job satisfaction; and (vi) information. Of the 10 tasks found to occupy most time, the primary ones were typing, taking dictation, and filing case notes. Most staff reported aspects of the physical environment as unsatisfactory such as lack of space, overcrowding, poor ventilation, draughts and noise. Eighty-eight per cent regarded the amount of work they had to do as reasonable, perhaps with some peak loading. A rather higher percentage of hospital office staff complained of physical discomfort (such as back pain or headache) than employees in the retail or catering trades. The connection between discomfort and the physical environment was closest in the case of noise, and slightly less certain for dry air, poor ventilation, and overcrowded offices. Two-thirds of the staff found their work too monotonous. The social environment was found satisfactory, although stress was occasionally experienced by two-thirds. The most irritating factor was the interruption of work in order to do 'more urgent' work. The most important factors for a good atmosphere are good colleagues and superiors, opportunities for contact with other people, and job security.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 956, 957, 960, 1007

952. DORENFEST, Sheldon I. **Hospital's computer costs will rise dramatically during next five years.** *Modern Healthcare*, Chicago, Ill., 1980, May, vol. 10, no. 5, pp. 73, 74, 76.

Preliminary results are presented of a survey of computer costs in United States hospitals. Of 250 hospitals interviewed, 216 were computer users and 201 provided

estimates of the expenditure of their computer departments in 1979. The computer users were divided into three primary approaches: in-house only; shared only; and shared for finance and in-house for other. The results are presented in four tables showing: total costs by approach; cost per bed by size of hospital and approach; computer costs as a percentage of total operating costs by size of hospital; and costs by approacn and size of hospital. In-house only users spent a greater proportion of their budget on computers, but this was primarily due to characteristics such as hospital size and type and number of applications rather than to the computer approach used.

953. DOWLING, Alan F. **Hospital staff interference with medical computer system implementation: an exploratory analysis.** Cambridge, Mass., Alfred P. Sloan School of Management, 1979. 56pp. (Working Paper 1073-79)

Although computerized information processing technology has existed in a commercially available state for over 20 years, its use in health facilities has lagged behind its use in even medium technology industries. When an automated data system is used in hospital the author estimates that there is a 45 per cent possibility of staff interference with its implementation. Case studies are presented of staff sabotage, which mainly consists of the falsification of data input to the computer. The author considers that many failures in computer implementation may have been the result of staff resistance.

954. HONKANEN, Risto and MICHELSSON, Jarl-Erik. **Construction of the computerized accident registration system in a casualty department.** *Scandinavian Journal of Social Medicine*, Stockholm, 1980, vol. 8, no. 1, pp. 33-38.

The casualty department of the University Central Hospital of Helsinki treats between 30,000 and 40,000 fresh injuries annually. A computerized statistics system was adopted in 1942; it used the official Finnish abridged version of the E code of the seventh revision of the International Classification of Diseases (ICD) and its fourth digit place code for non-traffic accidents. Because of unsatisfactory aspects of this system a new classification system was developed. It uses 50 accident types following the three-digit E code of the eighth revision of the ICD, with the following adaptations: (i) at several points, two or more adjacent categories are combined; (ii) at two points a category was split into sub-categories; and (iii) for traffic accidents the code followed the fourth digit sub-classes of motor vehicle accidents in the Scandinavian E code. Tables present this classification, and a new place of accident classification, with the percentage distribution of fresh injuries in 1976. Possible improvements in the system are discussed. The main benefit of the system is that it can assist in the identification of high injury risk areas of the community.

955. WARNER, Homer R. **Computer-assisted medical decision-making.** London, Academic Press (London), 1979. vii, 190pp. ISBN 0 12 735750 5 £11.80

Over the last 30 years almost all efforts to improve medical diagnosis have been directed toward the development of better data acquisition technology. Relatively little research has approached the problem of how to interpret data and use it for medical decision-making. This book brings together facets of the problem and is

designed to be used in several ways: (i) as a basis for a course on the fundamentals of decision-making for medical students; (ii) an introduction to the use of computers in clinical medicine for the physician; (iii) the use of computers for solving problems for the engineer and computer scientist; and (iv) for paramedical staff. The material in each chapter is presented from both medical and technical points of view. The chapters deal with: (i) an introduction to decision-making; (ii) sources of medical data; (iii) the patient data file; (iv) computer representation of medical knowledge; (v) modes of consultation between clinician and machine; and (vi) the computer as a training tool for medical decision-making.

INFORMATION SYSTEMS

See also Abstract No. 1002

956. DOYLE, Owen. **Data base: new management power.** *Modern Healthcare*, Chicago, Ill., 1980, May, vol. 10, no. 5, pp. 88, 90.

A new technique called data-base management is slowly becoming available from computer makers and systems firms. It will provide hospital administrators with a powerful planning and control tool—a true management reporting system. However, care should be taken in evaluating a 'data-base' system because the term has been used indiscriminately to describe everything from a file drawer filled with reports to a traditional computer system. The true test from the administrator's point of view is the speed and ease with which the system can generate special reports. Diagrams illustrate the traditional and data base computer systems and a true reporting system. The data base approach promises two major advantages: reduced clerical and programmer costs; and far more powerful and satisfying reporting.

957. WELCH, Jacqueline. **Computerised information retrieval services in a teaching hospital.** *British Medical Journal*, London, 1980, June 14, vol. 280, pp. 1433, 1434.

The Wessex Medical Library of the University of Southampton is one of an increasing number of institutions that now provide online information for clinical research and teaching staff. The library uses the British Library Automated Information Service (BLAISE) which provides access to a range of data bases. The most heavily used is Medline, which satisfies 70 per cent of requests at Southampton General Hospital. Others include Toxline, the Registry of Toxic Effects of Chemical Substances (RTECS), Chemline and Cancerline. At the Southampton General Hospital branch of Wessex Medical Library an average of five online searches are executed every working day. At a current charge of £30 an hour connect time, plus some extra charges, users do not seem inhibited about demanding these expensive searches. Obviously they find them cost-effective. There may be others deterred by the cost, in which case it might not be possible to meet the demand if charges were reduced considerably.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract Nos. 959, 1021

MEDICAL RECORDS

See also Abstract No. 994

958. CUMMINS, Richard O., SMITH, Robert W. and INUI, Thomas S. **Communication failure in primary care: failure of consultants to provide follow-up information.** *Journal of the American Medical Association*, Chicago, Ill., 1980, April 25, vol. 243, no. 16, pp. 1650-1652.

In a two-physician general practice within 80 km of two University medical centres, there were 4,367 patient visits in a six-month period from which 233 referrals (5.3 per cent) were made to consultants. All referred patients were accompanied by referral material and a request for follow-up information. The overall rate of receiving follow-up information was 62 per cent. Private specialists provided substantially more follow-up information (78 per cent) than either university-affiliated emergency rooms (48 per cent) or university-affiliated specialty clinics (59 per cent). Patients requiring continuing medical supervision from the referring physician also fared poorly: follow-up information for them was provided only 54 per cent of the time. The timeliness and method of providing follow-up information were examined and found to be satisfactory when follow-up information was provided. Possible explanations for the poor communication from the two University medical centres are examined. Substantial improvement could take place at once if consultants became more aware of the simple fact that the local physician is often a concerned, conscientious person worthy of receiving better communication.

959. HALL, J. and WHITE, R. **Organisation and methods investigation on microfilming of hospital patients' records in the Coleraine, Ballymoney and Moyle District.** [Belfast], Department of Health and Social Services, Work Study Organization and Methods Branch, Research and Intelligence Unit, 1978. [ii], 37pp. (16285/77)

Microfilming of hospital patients' medical records has increased due to a lack of storage space in most hospitals and the reluctance of many consultants to destroy any records. Many hospitals in the United Kingdom have become involved in microfilming. This report contains detailed feasibility studies undertaken in hospitals within the Northern Area Board in Northern Ireland.

960. TOMPKINS, Bonnie Marshall and others. **A computer-assisted preanesthesia interview: value of a computer-generated summary of patient's historical information in the preanesthesia visit.** *Anesthesia and Analgesia*, Cleveland, Ohio, 1980, Jan., vol. 59, no. 1, pp. 3-10.

A computer interview used to obtain a medical history of a patient before undergoing anaesthesia has been developed and tried out at the University of Wisconsin Center for Health Sciences. Using a video monitor and a keyboard computer terminal, patients were questioned on admission about their previous medical, surgical and anaesthetic history, drugs taken and allergies. The computer-generated information was compared with that derived from personal interviewing of patients by anaesthetists. The computer

interview was more accurate and less variable than the anaesthetist's in listing correct and relevant historical information. Items missed by anaesthetists included angina, myocardial infarction, recent respiratory infection and asthma. When the anaesthetist visited the patient before the operation, his assimilation of information about the patient was greater than when the summary was not used. In addition, there was more agreement between the computer summary and his own. Items showing improved agreement included level of physical activity, alcohol use and smoking. These findings show that a computer survey of a patient's history can enhance the anaesthetist's assimilation of relevant information. The anaesthetists saw the interview as an effective aid and it was accepted well by patients.

961. WAINWRIGHT, Lorna. **Trying to put the world's records straight.** *Health and Social Service Journal*, Basingstoke, 1980, May 16, vol. 90, no. 4693, pp. 630, 631.

In the United States, Canada, Australia and the Netherlands there are training schools for medical records officers providing two-year full-time courses. The only training schools in the United Kingdom are those established by the Association of Health Care Information and Medical Records Officers at Bristol Royal Infirmary, Western Infirmary (Glasgow), St. Thomas' and St. George's hospitals (London) but few full-time students have taken advantage of the scheme. Other contrasts are drawn with foreign experience, and brief summaries given of the papers from an international congress on health records.

HOSPITAL STATISTICS

See also Abstract Nos. 904, 949

962. MOORES, Brian. **Making use of the tools which are available.** *Health and Social Service Journal*, Basingstoke, 1980, May 2, vol. 90, no. 4691, pp. 578-582.

This paper is an attempt to suggest how the National Health Service could use some of the tools developed in a variety of research projects over the last few years to monitor the services provided in various districts and hospitals as an aid to better management. What is required are tools which will not only show how one hospital compares with another, but will also enable the manager to gain a 'feel' for the situation in that particular institution. Using examples taken mostly from work at the University of Manchester Institute of Science and Technology, the author discusses available statistics and the ways in which they can be used. It is shown that there is a great deal of statistical material lying around waiting to be used. Some of the effort currently directed at collecting and processing less useful data could be used to exploit the more important material.

963. UNITED STATES. NATIONAL CENTER FOR HEALTH STATISTICS. **The status of hospital discharge data in six countries, by Lola Jean Kozak, Ronald Andersen and Odin W. Anderson.** Hyattsville, Md., National Center for Health Statistics, 1980. vi, 77pp. bibliog. (Vital and Health Statistics Series 2 No. 80; DHEW Publication No. (PHS)80-1354) ISBN 0 8406 0186 7

The availability, comparability and quality of statistics for Australia, Canada, England, Wales and Finland, France and Sweden are discussed. A description is given in each case of the discharge data reporting system, with emphasis on coverage, types of data collected, procedures and definitions used. Some consideration is given to the health service characteristics that affect the use and nature of these statistics.

LEGAL AND ETHICAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 929, 939, 1010

964. CURTIN, Leah L. **Is there a right to health care?** *American Journal of Nursing*, New York, 1980, March, vol. 80, no. 3, pp. 462-465.

The author discusses the validity of 'a right to health care'. It is not easy to define health, but an adequate definition for ensuring the essentials of continued life and growth of the human being encompasses the areas of prevention, treatment and rehabilitation. Every human being has a right to health services which ensure adequate, but not necessarily optimal, functioning. Additional health services may be seen as 'wants' but not 'rights'. Those services which fall within the scope of 'rights' are hard to decide upon, but they must form the basis of a health service budget. When allocating resources, there may be controversy between the claims of prevention and treatment of disease. However, at the core of the right to basic care lies the obligation to treat those already sick. In return, people should aim to preserve their health through regular habits of eating, sleeping and exercise. Rights to care, places great responsibility on health care professionals in delivering care, and on planners in organizing its distribution, especially when resources are scarce. Individuals are seeking protection from an over-powerful health service which is sometimes accused of shifting concern away from the welfare of the individual. To achieve a proper balance, health professionals should care primarily for individual patient rights, while health planners must primarily represent the welfare of society.

FINANCE AND ACCOUNTING

FINANCE

965. ALLSTED, T. Budsjettet—sykehusenes viktigste verktøy for planlegging. **[The budget—the hospital's most important planning tool.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 4, pp. 14, 16.

The hospital's budget is an essential tool in planning, providing, as it does, a financial blueprint of its operations and a guide to future expenditure and income. The author stresses the importance of the availability of statistical data for the preparation of the budget itself and in establishing administrative control over the hospital's functional activities. This data should provide a basis for the distribution of current and future expenditure between departments and indicate actual and expected income from each department.

966. LASH, Myles P. **Financing hospitals and clinical pharmacy services.** *Hospital Pharmacy*, Hagerstown, Md., 1980, Feb., vol. 15, no. 2, pp. 78, 79, 82, 83, 86-88.

This paper discusses three topics that are important because of their special relevance to financing clinical pharmacy services: expenditure control; reimbursement management; and revenue generation. It then outlines the development of new pharmacy programmes at the Ohio State University Hospitals, and the process by which reimbursement approval for them was obtained from third-party payers. Success in this venture required high quality professional leadership in the pharmacy department, pharmacy staff who maintain an interest in the broad scope of patient care services, a good understanding of the institution's reimbursement environment, an understanding intermediary, and co-operative administrative staff.

967. VERHEYEN, P. A. De voorwaarde voor budgetteren. **[Basic hospital budgeting requirements.]** *Ziekenhuis*, Utrecht, 1979, Oct. 17, vol. 9, no. 20, pp. 508-511.

The health service, being hierarchical, has different levels of responsibility. Government is responsible for the health service as a whole, deciding the percentage of the national income to be spent on it, and also the distribution of such expenditure between the various sectors. The authorities also lay down general guidelines, e.g. wage scales, maximum numbers of beds per thousand inhabitants, numbers of places at medical schools, etc. A certain budget is given to the hospital sector, and an external budget is laid down for each hospital for expenditure on buildings, staff and running expenses. This budget is determined from national norms, e.g. an amount depending on the type of hospital, specialties, or training functions. Within its financial framework the hospital has room for medical optimization. Good internal budgeting is necessary, based on diagnosis categories, their relevant cost profiles and prediction of admissions per diagnosis category. This internal budgeting is patient-oriented and comparison of alternative methods can be made on the basis of these budgets. The success of a budget system depends on the co-operation of the medical and nursing staff; they decide on the basic activities which incur the costs. The cost consciousness of the staff decides whether the limited means of the health service will be used efficiently in the future.

COSTS

See also Abstract Nos. 952, 976, 1016, 1029, 1031

968. BELLAVITA, Christopher. **Public policy and the cost containment problem.** *Hospital Forum*, San Francisco, Calif., 1980, March, vol. 23, no. 2, pp. 53-56.

On 16 November 1979 (the day after the United States House of Representatives defeated the President's latest hospital cost control plan) 50 representatives of medical, hospital, business, labour, insurance, consumer, government and other groups active in helping to shape California's health policy, met to analyze what could be done about the 'health cost crisis'. The participants worked in small teams to identify the nature of the cost problem and to develop politically feasible solutions. They identified a number of social, institutional and individual factors that contribute to the high cost of health care and the many, far-reaching consequences. Three general approaches could be used

to solve the problem: (i) normative—if people recognize the problem they ought to change their profligate behaviour; (ii) market—people and organizations behave in ways that are beneficial to them; and (iii) regulatory—people have to be coerced into doing what is right. The conference also identified four ways a policy decision could be made: go directly to the people; go to the state legislature; set up a health policy advisory board independent of government; or do nothing.

969. GERAEDTS, H. and others. Kostenbewustzijn, een kwestie van mentaliteit en informatie (voorziening). **[Cost consciousness: a question of attitude and information.]** *Ziekenhuis*, Utrecht, 1979, Oct. 17, vol. 9, no. 20, pp. 513-516.

The authors of this article are four students of the Institute of Hospital Science at Utrecht University. Their two premises for the investigation were that: (i) concern for cost limitation in the health service on a macro level can only be effective if it is also shared by staff and patients on a micro level; and (ii) the cost consciousness is only possible when sufficient information is given to hospital staff about finance. A questionnaire put to hospital staff enquired into: sources of information; the way these sources were handled; what knowledge and opinions the individual member had of various cost categories; and what connections there were between receiving and handling information about costs. Two hundred and sixteen people chosen at random out of the 578 staff of a medium-sized general hospital were canvassed, the majority being higher level staff. The response was 52 per cent. The questions were on: (i) cost of care, number of staff and percentage of beds occupied: (ii) whether adequate information was received on the costs of the hospital; and (iii) whether adequate information was received on the cost of running their particular department. The provision of information on costs to hospital staff was found to be inadequate.

970. GOLDBERG, Lawrence G. and GREENBERG, Warren. **The competitive response of Blue Cross to the health maintenance organization.** *Economic Inquiry*, Long Beach, Calif., 1980, Jan., vol. 18, pp. 55-68.

In the United States most medical care is delivered on a fee-for-service basis, thus providing an incentive for physicians to see patients, to order tests, and to admit patients to hospital so as to increase income. In contrast, health maintenance organizations (HMOs) which are basically prepaid plans, have incentives to control costs. Other studies have shown that HMOs reduce hospital use and offer greater benefit packages than fee-for-service. This paper uses cross sectional regression analysis of 1974 data to test whether the presence of HMOs provides effective competitive pressure on Blue Cross, the largest insurer of hospital costs. The analysis supports the hypotheses that Blue Cross has reduced hospital use and increased benefit packages in response to the competition being provided by HMOs. It is concluded, therefore, that competitive forces do operate in at least one aspect of health care.

971. MCLAUGHLIN, Herbert, GROAT, Linda and SCHWARZ, Kenneth. **Economics of private rooms change.** *Modern Healthcare*, Chicago, Ill., 1980, May, vol. 10, no. 5, pp. 66, 67, 70.

The economics of nursing units with all single rooms have changed in the last five years, forcing hospital planners and designers to take a closer look at the costs and

benefits. A study of the costs and benefits of single and double rooms in three hospitals with single and multibed room units and one hospital with all single rooms is reported. It showed that a higher level of occupancy can be achieved in single beds enabling them to have fewer beds to meet the same demand. Even so the costs of construction, maintenance and patient care for a 36-bed all single rooms unit are higher than those for a 40-bed all double rooms unit. A combination of single and double rooms may increase efficiency and cut costs. The benefits from single rooms are considered to outweigh the costs. They include: greater privacy for patients; superiority in emergency situations; and fewer medication errors.

972. SCITOVSKY, Anne A. and MCCALL, Nelda. **Use of hospital services under two prepaid plans.** *Medical Care*, Philadelphia, Pa., 1980, Jan., vol. 18, no. 1, pp. 30-43.

Two comprehensive prepaid health plans are offered by Stanford University to its employees and their families: (i) a Kaiser-Permanente plan; and (ii) United Medical Clinics/Blue Cross plan (Clinic plan) under which physicians' services are provided by Palo Alto Medical Clinic and hospital services are covered by Blue Cross. Using age and sex-adjusted data, the hospital admission rates per 1,000 person years were 44.2 under the Clinic plan and 38.2 under the Kaiser plan; the hospital days per 1,000 person years were almost identical 250.7 and 249.8 respectively. The difference in admission rates was due to the higher surgical admission rate under the Clinic plan (32.4 and 25.0 respectively). However, when surgical procedures performed in the hospital on a non-admission basis were added to surgical admissions, the surgical rates under the two plans became very close. This lends some support to the hypothesis that the lower hospital surgery rates found under prepaid group practice plans may be due as much to the group practice form of their organization as to their prepaid feature. Possible reasons are suggested as to why surgeons in fee-for-service group practices may have relatively low surgery rates even though they do not have the incentive to hold down costs which surgeons in prepaid group practices have.

973. SEIDMAN, Laurence S. **Hospital inflation: a diagnosis and prescription.** *Challenge*, White Plains, N.Y., 1979, July/Aug., vol. 22, no. 3, pp. 17-23.

Any market will fail if a third party pays virtually 100 per cent of the bill for most consumers. Although many observers of the rapid hospital inflation in the United States have recognized the inflationary impact of complete insurance, it has generally been assumed that concern for equity prohibits the use of consumer cost-sharing, that is the payment of a fraction of the hospital bill by the patient. Moreover, it is often taken for granted that such cost-sharing would be ineffective because physicians, not patients, make most medical decisions. While cost-sharing unrelated to income would be inequitable, a tax credit on the federal personal income tax would make it feasible to gear cost-sharing to each consumer's ability to pay. Despite the key role of the physician, income-related cost-sharing should succeed in reducing hospital inefficiency, and is preferable to reliance on government regulation. Under the medical tax credit, a family would have to bear an initial percentage of its annual medical bill; it would then file for a tax credit equal to a specified percentage of its additional bill until a ceiling was reached. Such a system would depend on: (i) guaranteed convenient access to

medical loans; (ii) the ending of tax subsidies to occupational health insurance; and (iii) households paying complete private insurance would not be eligible for the tax credit.

974. ZOOK, Christopher J. and MOORE, Francis D. **High-cost users of medical care.** *New England Journal of Medicine*, Boston, Mass., 1980, May 1, vol. 302, no. 18, pp. 996-1002.

This study exposes the characteristics of high cost hospital patients in the United States by analyzing 2,238 medical records randomly selected from 42,880 discharges from six different hospital populations in 1976. On average, the high cost of 13 per cent of patients consumed as many resources as the low cost 87 per cent. Repeated stays in hospital for the same disease were more characteristic of the expensive patients than single cost intensive stays, or long single stays. About two-thirds of the high cost patients had repeated stays in hospital in one year and suffered from six diagnostic categories: (i) alcoholism and its effects; (ii) bowel disease; (iii) cancer; (iv) congenital defects; (v) renal failure; and (vi) chronic degenerative vascular heart disease. Potentially harmful personal habits, such as drinking and smoking, appeared more often in the records of high cost patients. Unexpected complications during treatment were five times more frequent in the high cost group. The high incidence of repeated admissions for certain diagnostic categories suggests that a large proportion of the total medical budget was predictable. However, significant savings in long term illness can be achieved through schemes for patient education and better use of ambulatory care.

HOSPITAL ACCOUNTING

See also Abstract No. 1045

975. CSIHAK, György. Kostenstellenrechnungen in einem Grossspital in der Schweiz. **[Cost accounting in a large hospital in Switzerland.]** *Krankenhaus-Umschau*, Kulmbach, 1980, April, vol. 49, no. 4, pp. 259-261.

The cost accounting system used in the Zurich University Hospital is described. The hospital is a complex of more or less independent departments and institutions with a total staff of 4,000, some 1,200 beds, 350,000 patient days (in 1978), and 120,000 out-patients (410,000 consultations) annually. Costs are divided into nine main groups and further subdivided: as an example the 16 subdivisions of the dermatological department are listed. The cost accounting system was introduced in January 1979.

976. MAGEE, C. C. and OSMOLSKI, R. J. **Speciality costs: an aid to planning and control.** *Hospital and Health Services Review*, London, 1980, June, vol. 76, no. 6, pp. 203-206.

The nature and function of costing are outlined. The basic purposes of expenditure analysis are planning and control, which are closely linked together. The important gap in the range of financial information which is currently available in the hospital service is an analysis of the expenditure between the different specialties and patient groups. The purpose of the Bridgend experiment was to develop procedures which would

regularly produce such financial information; specialty costings are now available for the three years to 3 March 1979. The use and evaluation of such costings is discussed and evaluated in relation to resource allocation, long-term planning, the links between financial cost and physical production, and the impact of inflation.

977. RÖHRIG, Richard. Die Entwicklung eines Kostenund Leistungs-Rechnungssystems als Grundlage für die Einführung des Controllingkonzeptes in Krankenhäusern. **[The development of a cost/efficiency accounting system as the basis for introducing the controlling concept in hospitals.]** *Krankenhaus-Umschau*, Kulmbach, 1980, April, vol. 49, no. 4, pp. 250, 253-258.

Since hospital problems do not differ basically from those of industrial undertakings it is considered that the concept of 'controlling' can also be applied in the hospital. Cost/efficiency accounting is regarded as a part of this concept within the tactical plan. The aims of cost/efficiency accounting include the following: economic control; comparison of performance and productivity; indication of cost-influencing possibilities; making staff cost-conscious; and revealing the nature of revenue costs. Cost/efficiency accounting divides into three areas: in regard to patient-related costs, to compare costs, performance and productivity; to check the efficiency of different services; and to determine the costs of alternative project proposals. There are 45 references to the relevant literature.

SUPPLIES AND STORES

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract No. 983

STORES

978. KOIVU, E. Sairaalan varastotoiminta. **[Storage in the hospital.]** *Sairaala*, Helsinki, 1979, vol. 42, no. 12, pp. 429-431.

In 1977 the district hospitals of the University Hospital of Helsinki had the following storage problems: (i) too little space, too scattered; (ii) delayed or insufficient deliveries; (iii) purchases of small quantities, from many sources; (iv) too wide a range of supplies; and (v) too little co-operation between hospitals. In exceptional conditions, the hospitals of this district can manage without new supplies for eight weeks on average. There must always be a slight over-stocking of basic medical materials in case of delays, and emergency supplies must be maintained, of from four to six months' basic medical material. This should not be kept separately from the active store because materials will only keep for a limited period. The commonest storage organization is the scattered system, each institution having a store of its own, and goods being purchased direct from the medical suppliers. An alternative system is the central store organization, goods being brought first to the central district stores. The advantages of this system are fewer deliveries and consequently lower costs, and fewer supplies stored in each institution. The disadvantages are the expense of running such a store, and the increase

in deliveries and transport from the central store. Stores accounting has been manual in all institutions except the University Hospital, which adopted computerization in 1973. Such a system can cover all the stores in a hospital district, provided the number of stores is reduced.

979. SMITH, Andrew and MOIR, Graeme. **Hospital stores: stock control and guidelines on accommodation.** Wellington, New Zealand Department of Health, Management Services and Research Unit, 1979. iv, 23pp.

The hospital services consume large amounts of materials annually—including medical and surgical items, bedding, linen and provisions. This publication has been prepared for those involved in planning and managing hospital supplies, and considers the control of stock and the accommodation requirements of hospital stores. Part A describes a formal method of stock control that has been designed to help minimize the costs associated with stocking items in hospital stores. Part B gives some guidelines on the accommodation requirements of such stores, assuming cost efficient stock control is in operation.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

980. ANDREIEV, Priscilla. **Health care: hospital food service earns competitive status.** *Institutions*, Chicago, Ill., 1980, March 15, vol. 86, no. 6, pp. 116-118, 120.

Competition for patients in American hospitals has made food service into a highly paid specialty and the health care industry now makes up 8.3 per cent of the food service market. A brief description is given of the activities of some of the major contract caterers and some of the developments in nutrition and food supply.

DIETETICS IN THE HOSPITAL

981. ANDERSON, Digby C. and STEPHEN, Cheryl. **The details of dietetic interviews: an initial assessment.** Nottingham, University of Nottingham, Leverhulme Health Education Project, 1980. [iii], 26pp. bibliog. (Occasional Paper No. 20)

In addition to a knowledge of the pure sciences dieticians need a grounding in the behavioural sciences, particularly subjects such as communication and education. The authors have made a detailed study of dietetic interviews in Nottinghamshire. They emphasize the need to preface interviews with an explanation of how long they will last, what they are intended to achieve and what is expected of the patient. The dietitian should ask questions that are open but return interviews to the subject if digression occurs. Some actual interview transcripts and a short bibliography are provided.

HYGIENE IN THE HOSPITAL

STERILIZATION

982. BECEL, D., LOISEAU, O. and DARBORD, J. C. Indicateurs biologiques d'efficacité pour le formaldéhyde. **[Biological indicators of the efficacy of formaldehyde.]** *Techniques Hospitalières*, Paris, 1980, March, vol. 35, no. 414, pp. 41-44.

A detailed protocol for the preparation from cultures of *Bacillus stearothermophilus* of biological indicators of the efficacy of formaldehyde cleaning and disinfection is presented. Four examples are given of the results obtained with the indicators when formaldehyde gas was used: (i) to clean a room used for the aseptic distribution of drugs; (ii) to disinfect a lock chamber; (iii) to disinfect a linen chest; and (iv) in an autoclave.

983. BERGE, T. Sterilsentralens plass i sykehusets forsyningstjeneste: driftsøkonomiske synspunkter på graden av sentralisering og bruk av engangs- og flergangsartikler. **[The role of the central sterile unit in the hospital supply service: a financial management view of levels of centralization and the use of disposable and multiple-use articles.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 1/2, pp. 3-7.

The supplies service must have strong central administration, with sub-sections for research (into supplies and hygiene), accounts and supplies including purchasing, intake, storage, central sterilization service and electromedical maintenance. The advantages of a central sterilization service are centralization of professional responsibility, specialized staff, and a basis for the purchase of the correct technical equipment—whether advanced or not. Productivity and turnover increase, and the advantages of standardization and centralized investment can be realized. One condition is, of course, that the institution must be persuaded to accept a sterilization centre, as a production unit. The disadvantages are: that a breakdown in any central service unit hits a wide area; certain types of instrument require special treatment and handling; and there is a requirement for increased stocks of multiple use items of a high degree of standardization and hygiene. The trend towards the use of disposables is bound to continue but it demands a high degree of knowledge and self-discipline on the part of the staff. The larger institutions have to keep the smaller units well informed on professional matters.

AIR HYGIENE

See Abstract Nos. 998-1000

DISPOSAL OF WASTE

984. KORN, Jørn and WARNØE, Kirsten. Kemikalieaffald og spildevand fra sygehuse. **[Chemical waste and sewage from hospitals.]** *Tidsskrift for Danske Sygehuse*, København, 1980, April, vol. 56, no. 4, pp. 42-45.

The disposal of chemical waste from Danish hospitals is governed by regulations promulgated in 1976. These are briefly described and the system of notifying

environmental authorities of the nature and quantities of such wastes explained. An enquiry among 56 hospitals revealed the average annual quantity of certain chemicals used per year and the amount per bed/year. The figures given in this paper include those for the following substances: mercury; silver; phenol; quaternary ammonium compounds; barium sulphate, aldehydes, organic solvents, penicillin, sulphonamides, 'other biotics', and 'other substances'. There were considerable variations between hospitals. It is concluded that if hospitals adhere to the principles laid down in the regulations they cannot be regarded as an important source of chemically contaminated waste water.

985. LÖÖF, R. Nya anvisningar förenklar hanteringen av sjukvårdsavfall. **[New directives simplify hospital refuse handling.]** *Sjukhuset*, Göteborg, 1980, vol. 57, no. 2, pp. 73-76.

Two procedures have been laid down for disposal of hospital refuse, according to whether the municipality has its own incineration facility, or a dump or compost unit. Treatments covered by the legislation comprise: burning in conventional incinerators, in high-risk units and by pyrolysis; composting and/or separation; and dumping. The regulations also cover disposal of laundry and of the bags in which it is transported. Infected water from hospitals and their laundries requires special treatment in a manned unit to prevent the spread of infection. The regulations are listed in detail. The article is illustrated with two clear flow charts showing the treatment of high risk refuse and conventional refuse under the two systems.

SAFETY MEASURES

See also Abstract No. 1004

986. SJÖLENIUS, Bengt. Det sårbara sjukhuset. **[The vulnerable hospital.]** *Sjukhuset*, Göteborg, 1980, vol. 57, no. 4, pp. 261, 264, 267.

A committee set up by Stockholm County Council has pointed out that staff measures in health establishments are not always satisfactory and recommends the setting up of an organization with the following aims: (i) prevention of fire outbreaks; (ii) if fires occur to keep to a minimum, harm to people and damage to buildings and equipment; and (iii) the prevention, as far as is possible, of theft, violence and threatening behaviour. Under each of these three heads the problems which arise, and their solutions, are discussed.

THE PATIENT

ADMISSION AND RECEPTION

987. GILLEBEERT-FELIERS, M. De opnamedienst in het ziekenhuis. **[The hospital admission service.]** *Hospitalia*, Brussel, 1979, vol. 23, no. 3, pp. 145-147.

Admission to hospital is for the patient, comparable to emigration to a foreign land whose language he does not speak. For the staff, admitting a new patient is an everyday event which they are used to: they neither notice nor feel the patient's

inadequacies or fears. The patient's first contact with the hospital must be friendly, personal and informative, since first impressions are decisive for the patient's attitude. Everyone on the hospital staff should ask himself 'how would you yourself like to be admitted, instructed, spoken to and nursed?' Patients nowadays can be demanding but being confronted with the vulnerability of their own bodies is something they are not really equipped to meet. Particular problems arise in the case of children, old people and acute admissions. Sometimes the relatives are more in need of help than the patient and a human, tactful approach is needed in all cases.

WELFARE OF THE PATIENT

See also Abstract Nos. 981, 1010, 1022, 1023, 1040

988. BOKMA, J. Uniforme bezoektijden zijn nauwelijks te realiseren. **[Difficulties of obtaining uniformity in hospital visiting hours.]** *Ziekenhuis*, Utrecht, 1979, Nov. 21, vol. 9, no. 22, pp. 558-560.

Few Dutch hospitals have flexible visiting times. Neither the hospitals nor the public are satisfied with the plethora of regulations in force, although uniform visiting hours throughout Holland would not be feasible in practice. Patients cannot have visitors at peak periods of staff activity. Doctors' rounds, washing and cleaning activities, and the work of the laboratories and X-ray department all have to be planned, many of them within the daytime working hours. Another factor is the fundamental attitude of the hospital organization to the patient's stay. One opinion is that the patient comes to the hospital temporarily and must be got out again as quickly as possible; everything is aimed at as rapid and efficient a cure as possible, with as few disturbances by such irritants as visitors as possible. The opposite viewpoint finds it important for the care of the patient for there to be ample visits, maintaining contact with the usual environment and making the stay in hospital more varied. The facilities available in the hospital buildings are also significant. There may be crowded wards with nowhere for the patients to sit with the visitors and have a cup of tea. The fact that nothing ever seems to result from questionnaires among patients and visitors is not indicative of a lack of readiness for change on the part of the hospital but more of technical difficulties and perhaps an obscure presentation of the problems.

989. RAMSDEN, Elsa L. **Values in conflict: hospital culture shock.** *Physical Therapy*, Washington, D.C., 1980, March, vol. 60, no. 3, pp. 289-292.

Many health professionals have been surprised and dismayed by manifestations of public pressure and even hostility towards them, exemplified by the drive for patient rights and an increase in malpractice suits. A variety of contemporary trends have converged to produce such results. It is suggested that underneath the problem lies a conflict in values between many health professionals and the people who are their patients. The individual who becomes a patient brings to the health care setting needs, values and a life style founded on a highly individualistic personal history and experience. The process of health care and the manner in which it is negotiated are largely controlled by the health professional. Success or failure of treatment and ultimate progress of the patient may depend upon the resolution of this fundamental conflict of values. The

role of the health professional is to provide adequate information in a manner comprehensible to the patient, to create a treatment environment characterized by honesty, and to develop a relationship based on trust.

990. ROSLANIEC, Anita and FITZPATRICK, Joyce J. **Changes in mental status in older adults with four days of hospitalization.** *Research in Nursing and Health*, Easton, Pa., 1979, Dec., vol. 2, no. 4, pp. 177-187.

A study was undertaken to determine the changes that occur in the mental status of older patients during four days in an acute care setting. It aimed at testing the hypothesis that elderly patients would experience significant changes in all components of mental status (level of consciousness, orientation, attention/concentration, memory, higher cognitive functions) during this period of time. A sample of 25 patients aged from 65 to 89 years in a 400-bed acute general hospital had their mental status evaluated twice: (i) on the afternoon of the day of admission; and (ii) on the fourth day in hospital. A specially-designed mental status examination was used in a 20-minute interview with each patient. Statistically significant changes were found in three components of mental status: disorientation increased; level of consciousness declined; and memory improved. The significance of these findings for nursing is discussed.

HOSPITAL SOCIAL WORK

See Abstract No. 1049

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract Nos. 909, 958

TRANSPORT OF PATIENTS

991. BALL, Terry. **A share in the caring.** *Health and Social Service Journal*, Basingstoke, 1980, June 13, vol. 90, no. 4697, pp. 776-778.

This article describes how an ambulance crew in the West Yorkshire Metropolitan Ambulance Service was trained to help care for elderly patients at a new psycho-geriatric day hospital at Bingley Hospital. Before the day hospital opened, four new ambulance staff were appointed. It was estimated that these four staff working with two vehicles could deal with the work load of about 90 patients carried to the hospital daily. The crew were trained strictly for non-emergency work and notes for instructors were produced with particular reference to: (i) geriatric patients; (ii) mentally ill or handicapped patients; and (iii) physiotherapy patients. The induction course for the new crew included a week of lectures in the hospital and visits to the psycho-geriatric day hospital and the physiotherapy department, to give the ambulance men the chance to build up a relationship with both patients and staff. The men also acted as a communication link between patients and their relatives. Since the introduction of the special training course, there has been a significant improvement in every patient attending Bingley Hospital as a day patient or out-patient.

HOSPITAL CARE

See also Abstract Nos. 929-931, 934, 935, 945, 946, 974, 1017, 1018, 1025-1028, 1039, 1043

992. ANDERSON, Marcia and CHOI, Thomas. **Primary nursing in an organizational context.** *Journal of Nursing Administration*, Wakefield, Mass., 1980, March, vol. 10, no. 3, pp. 26-31.

Current definitions and philosophical bases for primary nursing care are discussed. Synthesizing past and present data, the authors suggest a new definition that takes the organizational context into consideration. Primary nursing is a system organized to maximize continuous and comprehensive delivery of nursing care to patients. Emphasis is on one nurse having professional/organizational autonomy in assuming responsibility and retaining accountability for planning and, when possible, personally administering total care to designated patients throughout their stay in hospital. Ideally, this responsibility is expanded to include such patient episodes as readmissions, home care, clinic visits and other out-patient related activities. This definition is extended in tabular form listing: activities of primary nurses; maximum and minimum levels of achievement for the various activities; and a set of basic organizational requirements associated with each primary nursing activity that facilitate or impede primary nurse effectiveness.

993. HAGENDOOM, L. M. and NIJHUIS, H. Experiment teamverpleging bevestigt verwachtingen. **[Team nursing experiment comes up to expectations.]** *Ziekenhuis*, Utrecht, 1979, Dec. 19, vol. 9, no. 24, pp. 632-634.

An investigation was carried out into the hypothesis that team nursing improves the quality of care but needs more staff than traditional nursing. Eleven hospitals, some with experience of team nursing and others agreeing to act as controls, were visited, a medical ward being selected at each hospital. The two questions asked were: (i) what consequences does team nursing have for the patient, the working methods of the nursing staff, and their attitude to their work; and (ii) what are the consequences on staff establishment. Measurements were made at various intervals of work load, time required and quality of care, based on a period regarded by the staff as normal. Team nursing did not seem to require more staff; the extra time spent on communication was offset by better internal organization of activities and less time wasted. Quality of nursing appeared to be higher. When changing to team nursing it is necessary to inform all disciplines within the hospital beforehand and to discuss the organization of the system with the entire nursing staff in order to ensure their co-operation.

994. KERR, D. N. S. **POMR and the curate's egg.** *Update*, London, 1980, June 15, vol. 20, no. 12, pp. 1569, 1570, 1574-1576.

Weed developed and advocated the problem-oriented medical record (POMR) because the traditional record often fails for three reasons: (i) doctors do not define the problems; (ii) they state no reasons for their actions; and (iii) they miss vital information buried in a great 'information dust-heap'. Advocates of the POMR tend to assume that POMR and traditional records are mutually exclusive; few try to analyze

it and enquire whether it is good in parts. The author has introduced some of its features with limited success in a British hospital. The problem has been placed at the front of case notes; it is augmented throughout the hospital stay and revised when the patient is discharged. The statement of reasons for actions taken was not adopted. To make the information in the record more readily available: a filing list has been introduced on the inside front cover of case notes; laboratory results are transcribed on to a flow sheet; and a four-position folder has been developed. This modified POMR has assisted in the improvement of patient care, but is more costly in medical and secretarial time.

995. NURSING PRACTICE RESEARCH UNIT and DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **The prevention of pressure sores: proceedings of a conference at the Nursing Practice Research Unit.** London, Department of Health and Social Security, [1980]. 35pp. bibliogs.

This booklet contains a series of papers on the subject of pressure sores and their prevention delivered at a conference of the Nursing Practice Research Unit. Topics discussed include: (i) the extent and nature of pressure sores; (ii) their underlying causes; (iii) attempts to improve hospital beds; (iv) movement as a means of relieving pressure; (v) teaching and equipping the patient at risk; and (vi) patient support systems.

TERMINAL CARE

996. DUBOIS, Paul M. **The hospice way of death.** New York, London, Human Sciences Press, 1980. 223pp. bibliog. ISBN 0 87705 415 0 £10.95

This book examines new approaches to the understanding and treatment of the terminally ill and the subsequent development of hospices in the United States and Great Britain. Three case studies are given, including St. Christopher's Hospice in London and an American case where an attempt to set up a hospice failed. An extensive bibliography is included.

997. HATCH, Edward W. and BORING, Nathan L. **Regional hospice network offers system benefits.** *Hospital Progress*, St. Louis, Mo., 1980, March, vol. 61, no. 3, pp. 67-70.

The multi-institutional hospital system currently on the increase in the United States, can also be applied to hospice care. In January 1980, the East Central Illinois Health Systems Agency and three area hospitals established a hospice network in conjunction with the local Health Systems Agency. Each hospice programme in the network, which provides nine in-patient beds, retains its autonomy, but planning and programme evaluation is co-ordinated. The goals of the network are to co-operate to provide high quality, cost-effective care in the three hospitals in the region and to ensure eventual access to hospice care throughout the region. The objectives are: (i) to establish a co-ordinating steering committee; (ii) to diffuse hospice services to other health care areas; (iii) to provide continuing education for hospice staff; (iv) to develop treatment plans; (v) to develop evaluation of and research into the hospice system; and (vi) to

investigate financial reimbursement schemes for hospice services. The development of similar hospice networks should be encouraged in other regions to ensure the provision of suitable high quality care for the terminally ill.

DISCHARGE OF PATIENTS

See Abstract No. 963

HOME CARE, AFTER-CARE

See Abstract No. 958

SPECIAL DEPARTMENTS

OPERATING SUITES

998. McCUTCHEON, R. **Eliminating gas pollution in the O.R.** *Dimensions in Health Service*, Ottawa, Ont., 1980, March, vol. 57, no. 3, pp. 11, 12.

At Northwestern General Hospital, Toronto, a committee was set up to measure operating room pollution levels and to make recommendations to overcome the problem. Major areas of contamination included the area around the anaesthetic machine and the operating table, and in certain pockets in the rest of the room. A small portable nitrous oxide analyzer was used for quick and accurate results. The air exchange system in the operating room was found to be adequate. Gas evacuators were assessed and a Medishield product installed on the anaesthetic machine was chosen and found to work satisfactorily. Gas evacuators, vaporizer seals and valves, circuits, anaesthetic machines and ventilators are checked annually for proper function and the air is sampled periodically. The following conclusions can be drawn: (i) operating room pollution exists and may be harmful, but can be managed; (ii) a simple evacuation system can be used by all operating room staff; and (iii) anaesthetic equipment and levels of nitrous oxide in the air can be checked regularly.

ANAESTHESIA

See also Abstract No. 960

999. JACOBSEN, Vivi. Anästesigasser og deres indflydelse på arbejdsmiljøet. **[Anaesthetics and their effect on the working environment.]** *Sygeplejersken*, København, 1980, May 14, vol. 80, no. 19, perspektiv; pp. 3-22.

In a paper particularly aimed at anaesthesia nurses the author, herself an anaesthesia nurse, describes the characteristics of a number of anaesthetics used in operating suites. She is particularly concerned to indicate the possible harmful effects of these gases on the health of operating theatre staff. The gases dealt with are nitrous oxide, cyclopropane, halothane, ether and trichlorethylene. The details are set out in a series of 26 tables and are based on a review of the literature (there are 39 references).

1000. MAZZE, Richard I. **Waste anesthetic gases and the regulatory agencies.** *Anesthesiology*, Hagerstown, Md., 1980, March, vol. 52, no. 3, pp. 248-256.

A document was drawn up in 1977 setting out a permitted level of contamination and describing scavenging procedures. OSHA is now studying, but has not finalized, a standard with regard to waste gas levels. However, it has powers to inspect work premises for hazards, and inspection of operating rooms at Bethesda Hospital, Cincinnati resulted in the installation of monitoring systems. In 1976 the FDA proposed that manufacturers of anaesthetic equipment should determine the potential harmful effect of their drug products, but this was rejected. It appears that, as most hospitals in the United States have voluntarily installed waste gas scavenging systems, government intervention is probably unnecessary at this stage. Four national regulatory agencies in the United States are concerned with the possible hazards associated with contamination of operating rooms by waste anaesthetic gases. Three of the agencies are federal: the National Institute of Occupational Safety and Health (NIOSH), the Occupational Safety and Health Administration (OSHA), and the Food and Drug Administration (FDA). The fourth, the Joint Commission on Accreditation of Hospitals, is a private organization. NIOSH supported a national health survey of operating room staff in 1971. Hazards identified included adverse effects on reproduction, an increase in hepatic and renal disease and an increase in cancer among female staff.

1001. PARKHOUSE, James and PARKHOUSE, Hilda F. **Anaesthetic staffing and work in the North-western RHA.** *British Medical Journal*, London, 1980, May 24, vol. 280, pp. 1284-1286.

During 1977-78 a detailed study was made of anaesthetic staffing and work in the North-western Regional Health Authority to help provide a rational basis for allocating additional posts. The main findings are summarized in a table. The general picture is of a dynamic, overworked specialty constantly trying to catch up with the demands made on it and the additional demands created for itself. In this region, which is probably fairly typical, the provision of a truly comprehensive service with satisfying working conditions for all concerned would require many more anaesthetists than are available at present. However, such provision could be facilitated by well-trained nursing and technical assistants. Two points are emphasized: (i) anaesthetic work loads need to be assessed much more critically and sensitively than in terms of 'notional half days'; and (ii) the use of area or district population figures is an inadequate guide to the need for anaesthetic staff.

PHARMACY

See also Abstract Nos. 966, 1024, 1044

1002. BECKER, A., DAUPHIN, A. and THUILLIER, A. Organisation de la documentation d'une pharmacie hospitalière. **[Control of literature in a hospital pharmacy.]** *Gestions Hospitalières*, Mantes-La-Jolie, 1980, Feb., no. 193, pp. 149-154.

A system is described for classifying the literature received by the hospital pharmacy in such a way that the information which it contains can be easily retrieved. Documents are classified: (i) chronologically for reviews and periodicals; (ii) alphabetically

according to trade name for data sheets and information sent by the pharmaceutical industry; (iii) by accession number for information request slips, reprints, and summaries of research. The title, author, journal name, short summary of contents, and keywords are transcribed onto a filing card. The individual keywords are then entered on puched cards. The work of reading and selecting the documents, choosing the keywords, and recording the data on the cards takes about nine hours a week. This work is done by pharmacists and junior medical staff. The structure of the system is described step by step and three diagrams illustrate it.

1003. CHAUDHURY, Ranjit Roy. **Role of a clinical pharmacology unit at a teaching hospital.** *Journal of the Indian Medical Association*, Calcutta, 1980, Jan. 16, vol. 74, no. 2, pp. 40-42.

As the part played by a clinical pharmacology unit in a teaching hospital is not fully appreciated in India, the author discusses the type of work carried out by such a unit. Its main tasks are: (i) advising clinicians on problems of drug therapy; (ii) running a laboratory to study the use and interactions of drugs; (iii) recording and monitoring side effects of drugs in co-operation with nursing staff; and (iv) helping to chart the complex drug therapy of patients in intensive care units. In collaboration with other clinical departments, the clinical pharmacology unit should carry out research studies on the trials of new drugs in any field of therapeutics, including plant and herbal remedies. Advisory services can also be given in the form of providing: (i) information on the comparative merits of drugs; and (ii) assistance in preparing designs for clinical trials and analysis of data. The clinical pharmacologist should be an important member of the Hospital Drugs Committee and his team is the most appropriate unit to keep the national drug regulating agency informed about drugs that may need to be introduced to or removed from the Indian market. The unit should also: (i) teach drug usage to hospital staff; (ii) review the hospital's expenditure on drugs; and (iii) study drug usage in the out-patient department and in the local community.

1004. HAYMAN, Jimmy N. **Developing an educational safety program for pharmacy employees.** *Hospital Pharmacy*, Hagerstown, Md., 1980, Feb., vol. 15, no. 2, pp. 56-60.

After discussing the need for educational safety programmes for pharmacy staff, this paper presents a three-part programme as a guide for developing a departmental safety programme: (i) environmental hazards, such as wet floors, poor lighting and cluttered circulation areas, and precautions to be taken to avoid accidental exposure to patients with communicable diseases; (ii) hazards that may result from incorrect handling of materials and equipment, precautions for handling chemicals, needles, ladders and electrical equipment, and proper methods of lifting heavy objects; and (iii) plans to protect staff in the event of fire, including plans for reporting fires and evacuating the pharmacy and hospital. The outlined programme requires self-study by staff during initial orientation, followed by annual retraining. Staff should be tested and graded on safety topics, and training records filed for future reference.

1005. HOFFMANN, Richard P. **General suggestions for auditing antibiotic usage.** *Hospital Pharmacy*, Hagerstown, Md., 1980, March, vol. 15, no. 3, pp. 143-147.

The misuse of antibiotics in hospitals has been substantiated. It results in added costs, unnecessary adverse drug effects, inappropriate therapy, and growing bacterial resistance. Therefore, the Joint Commission on Accreditation of Hospitals requires the medical staff to review antibiotic use. The audit process should be multi-disciplinary involving, in addition to the medical staff, representatives from the nursing, pharmacy, microbiology and medical records departments. The review should be overseen by three medical staff committees: infection control, pharmacy and therapeutics, and executive. Areas for review should be selected on the basis of their potential to provide the most benefit. The criteria used in review should be selected because they are: developed with the help of the medical staff; limited to a realistically manageable number; selected on the basis of their importance to patient care and potential for improvement; validated by clinical research; and clearly written and explicit. Various systems can be used for collecting data and conducting the audit, but existing systems should be used wherever possible. Shortcomings found during the audit should be followed up as soon as possible with corrective measures. Educational methods should be used first; to be followed by more stringent regulatory efforts if they are ineffective.

1006. LOWTHER, T. R. **The provision of a 24-hour pharmaceutical service.** *Pharmaceutical Journal*, London, 1980, May 31, vol. 224, no. 6075, pp. 616, 617.

In 1976, the pharmacists of three large teaching hospital groups in Belfast sought and gained approval for a 24-hour pharmaceutical service. Criteria for the scheme included: (i) 24-hour provision of both supply and advice; (ii) the appointment of four additional pharmacists; and (iii) a 12-month pilot scheme to be carried out at one of the hospitals. The Belfast City Hospital was chosen for the pilot scheme which, with four newly appointed pharmacists to run it, went into operation in October 1976. The service was made available throughout the area within a few months, on condition that: (i) the requesting hospital provided transport to collect medicines from Belfast City Hospital; and (ii) the messenger produced a signed requisition form. In January 1978 the South District of Belfast reported that both medical and nursing staff had found the service most valuable in ensuring that patients' needs were met without delay. The service was made permanent in March 1978.

LABORATORIES

See Abstract No. 1020

BLOOD TRANSFUSION DEPARTMENT

1007. PAGE, B. **A review of computer systems in blood banks and discussion of the applicability of mathematical decision methods.** *Methods of Information in Medicine*, Stuttgart, 1980, April, vol. 19, no. 2, pp. 75-82.

The increasing demands made upon blood donor and transfusion services have necessitated the use of computer systems in several areas of the service. The following

fields in blood donation and transfusion seem particularly appropriate for the application of computers: (i) summoning blood donors for a donation or a medical check; (ii) record keeping; (iii) inventory and distribution of blood products; (iv) location of suitable blood in emergencies; (v) statistical reporting of recipient and donor data; (vi) medical records of transfusion recipients; and (vii) automated processing of laboratory data. The cost benefit of a computer system can be calculated by balancing the hardware and operating costs against cost savings in clerical staffing and improved performance in the medical field. Computer systems in operation or being developed for blood donor services in the United States, Sweden and West Germany are compared in tabulated form. The first developmental work in this field took place in the United States and Sweden, with West Germany following. Not all the systems cover the possible applications described in this article, but a further growth in computer use in blood donor services is certain to take place.

DIAGNOSTIC X-RAY DEPARTMENT

1008. McGUIRE, T. R. **Standards for radiology are made easier.** *Industrial Engineering*, Atlanta, Ga., 1980, April, vol. 12, no. 4, pp. 37-39.

Work measurement in the radiology department, with over 300 possible procedures, requires special attention when trying to establish standards. The radiology department of Latter Day Saints Hospital, Salt Lake City, Utah, and the other departments in the hospital first used time standards, based on the CASH method, in 1971. In 1974 new standards were calculated using the resource monitoring system. From 1971 to 1974 an apparent decrease in productivity occurred, partly due to a slight change in procedure mix towards more time-consuming procedures. Establishing a time standard for each procedure, a solution adopted in all other departments, was impractical in radiology. Routine time studies were performed for the eight most common procedures. The standards calculated were then classified into a set of time standard groups and used as reference procedures. Standards for all other radiological procedures were established by a team consisting of the chief technologist, and the hospital industrial engineer. At present a count is made each two-week period of every procedure performed. Productivity improvements have been made which amount to at least 2.4 full time equivalent staff.

1009. THOMPSON, Thomas T. and MUELLER, Helmut A. **Manpower requirements for radiologic technologists.** *Radiology*, Easton, Pa., 1980, May, vol. 135, no. 2, pp. 525-527.

A report from the Committee on Job Descriptions and Manpower Studies of the American College of Radiology and the American Society of Radiologic Technologists indicates that sufficient radiologists are being trained for the posts available. It is estimated that there are 130,000 radiographic machine operators employed in the United States, of which 100,000 are either registered or licensed by the appropriate bodies. A radiologist performs about 2,597 examinations per year, representing an average of 17.6 examinations per day in the East of the United States and 11.5 in the West. In 1976 there were 915 training programmes with a student capacity of 22,199, but most were not completely filled. There were no differences in salaries or job

opportunities for radiologists trained by degrees or by certificate-based schemes. Manpower needs are highest in the South, South-West and the Plains regions, with an excess in the West and North-East. Most qualified radiologists who leave the profession do so for personal, not financial, reasons. It is possible that too many radiologists are being trained and since 93 per cent of the work consists of routine examinations, a reassessment of educational requirements might be useful.

RADIOTHERAPY DEPARTMENT

1010. HORTY, John F. **Hospitals may need product liability immunity for therapeutic X-rays.** *Modern Healthcare*, Chicago, Ill., 1980, April, vol. 10, no. 4, pp. 108, 110.

Rulings by United States courts that blood must be treated legally as a product not a medical service led many state legislatures to pass laws specifically designating transfusions as a service and making blood immune from product liability litigation. This paper discusses a recent ruling by the Illinois appellate court that therapeutic X-rays are a product. Although the decision does not complete the case, it suggests that every patient undergoing therapeutic radiology must be read a statement explaining the putative dangers of X-rays. The application of strict liability in tort to patient care products and treatments may have unpleasant legal consequences for hospitals and add unforeseeable complications to patient medical care.

REHABILITATION

1011. MANNERBERG, Don. **Rehabilitation of cardiovascular diseases in a USA centre.** *Chest, Heart and Stroke Journal*, London, 1979, vol. 3, no. 5, pp. 62-65.

The Longevity Center at Santa Barbara, California, provides a residential therapeutic, dietary and exercise programme for people with atherosclerotic cardiovascular disease. A low fat, high fibre diet is combined with an exercise programme prescribed for each patient. Instruction is given in the nature and causes of atherosclerotic and degenerative disease and the role of the Center's approach to it. The patients attend voluntarily or are sent by their doctors and all are screened by a medical review committee. All 893 patients who attended the Center between April 1976 and October 1977 displayed significant changes in risk factors, including: (i) a drop in serum chlorsterol and serum triglyceride levels; (ii) a decrease in smoking; (iii) a lowering of blood pressure; (iv) a fall in blood glucose levels; (v) weight adjustment; and (vi) a drop in uric acid levels. Impressive improvements in functional capacity were accompanied by a decrease in the drugs taken. A planned six-monthly follow-up for five years of a group of patients will give more concrete evidence as to the relationship between exercise and diet and the risk factors associated with atherosclerotic disease.

1012. WINSLOW, Elizabeth Hahn and WEBER, Therese M. **Progressive exercise to combat the hazards of bed rest.** *American Journal of Nursing*, New York, 1980, March, vol. 80, no. 3, pp. 440-445.

It is only in recent years that progressive exercise has been recognized as a more effective method of cardiac rehabilitation than a long period of bed rest. A progressive

plan of active rehabilitation aimed at enhancing cardiac function and preparing the patient for discharge. During the first 21 months of the scheme, carried out at St. Paul's Hospital, Dallas, 300 patients took part, 70 per cent of whom had had myocardial infarctions. Each patient is classified according to medical history to determine the aims and speed of the activity progression, which in turn is based on a measurement of energy expenditure for various activities. The physiotherapist supervises the exercise programme, working closely with medical and nursing staff to co-ordinate activities of daily living and assess tolerance. Patients exercise for 20 minutes daily and are monitored for any abnormal responses. Classes for patients and their families are held five days a week and cover heart attack, angina, risk factors, drugs and diet. These group classes allow patients to learn from each others' experiences and to give each other emotional support, but they must be supplemented by individual teaching. Each patient is given written discharge instructions. Patient education has been helpful, if not entirely successful, in achieving patient compliance with treatment after discharge.

OCCUPATIONAL THERAPY DEPARTMENT

1013. College of Occupational Therapists. **Recommended minimum standards for occupational therapy staff patient ratios.** [London], College of Occupational Therapists, 1980. 15pp.

This document outlines recommended minimum standards for occupational therapy staff-patient ratios. In order to compile this, other aspects of the service have been considered. The two appendices attached to the tables give: (i) an average breakdown of how the staff spend their time, showing that an average of only 50 per cent of the working week is spent in direct patient contact; and (ii) the services and facilities necessary for an occupational therapy department to function effectively.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 937

1014. McComb, Harold. **The structure and function of the burns unit at the Royal Perth Hospital.** *Australia and New Zealand Journal of Surgery*, Sydney, 1979, vol. 49, no. 4, pp. 416-424.

The burns unit at the Royal Perth Hospital is laid out in the form of a U with a central service corridor down the middle. Basically there are nine beds (seven single and one double room) in the unit. When necessary, the unit can be expanded by opening doors in the outer, U-shaped corridor and using two additional four-bed rooms. When not required these rooms, which can be completely isolated, can be used by other departments. An operating theatre is also included in the unit. The procedures followed in the unit are described, with particular reference to the modified hospital bed which can be converted easily and cheaply into a bath-bed. Control of infection and early replacement of full thickness skin loss have been regarded as essential. The design of the unit provides flexibility, strict isolation when necessary, and easy physical handling of patients; together with the treatment regime, they have produced excellent results. A plan of the unit and photographs of the bath-bed are included.

INTENSIVE CARE UNITS

1015. AITKENHEAD, A. R., WILLIS, M. I. and BARNES, W. H. **An economical mobile intensive care unit.** *British Medical Journal*, London, 1980, May 17, vol. 280, no. 6225, pp. 1219-1221.

This paper describes the mobile intensive care unit developed to carry critically ill patients from other hospitals to the intensive therapy unit at the John Radcliffe Hospital and the neurosurgical unit at the Radcliffe Infirmary, Oxford. A hospital trolley has been modified to form the main part of the unit; its equipment is described. For journeys between hospitals the trolley is carried in a modified ambulance. The call-out procedure is described. Such units can be brought into service with low construction and running costs and enable the treatment and monitoring of critically ill patients to be maintained during transfer for specialist investigation or treatment. Photographs of the trolley and ambulance are included.

SPECIALIZED HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1042

1016. GOODRICH, Thelma Jean and GORRY, G. Anthony. **The process of ambulatory care: a comparison of the hospital and the community health center.** *American Journal of Public Health*, Washington, D.C., 1980, March, vol. 70, no. 3, pp. 251-255.

Harris County (Tex.) Hospital District operates a general hospital, a special hospital and eight community health centres. Since May 1977 all charts in the general medical and admitting out-patient clinics of the general hospital have been screened to identify patients who live nearer to one of the health centres than to the hospital. With their consent suitable patients are referred to a centre. In a study of 300 chronically ill patients referred it was found that the number of visits made, the amount of medicine prescribed, and the number of tests ordered all increased markedly in the six months following their referral. As a result, there were substantial increases in the charges incurred for their care. The care itself changed as well. The physicians at the centres differed on the whole from those at the hospital in the emphasis they placed upon various types of visits, medicines and tests. There were also large differences among the centres. The findings indicate the difficulty of providing comparable care at a comparable cost within a large health care system.

1017. GREENE, James Y., WEINBERGER, Morris and MAMLIN, Joseph J. **Patient attitudes toward health care: expectations of primary care in a clinic setting.** *Social Science and Medicine*, Oxford, 1980, March, vol. 14A, no. 2, pp. 133-138.

Patient satisfaction, defined as the degree to which patient expectations of health care are perceived as being fulfilled, has recently been emphasized in the evaluation of care. The study described aims to assess the expectations of 265 patients receiving

out-patient care at a teaching hospital in Indianapolis. Patient expectations were found to be generally high. An analysis identified three factors in patient expectations: (i) the role of the provider of care; (ii) the relationship between the patient and the physician; and (iii) the convenience of the service. The patient appeared to consider himself subordinate to the physician and did not consider it important that he should be provided with details about his medical problem. Expectations of non-physician providers of care were directed towards personal qualities only, but for physicians concern was with both professional competence and personal qualities. Patients were more concerned with the convenience than the cost of care, probably because costs among the population studied were paid by insurance schemes. It should be the task of future research into patient expectations to: (i) relate expectation to satisfaction with the service provided, compliance with treatment and final outcome; and (ii) compare the expectations of different social groups who receive care in a variety of settings.

CASUALTY AND ACCIDENT

See also Abstract No. 954

1018. SPITZ, Louis. **Problems in evaluating and treating psychiatric patients in a medical-surgical emergency-department setting.** *Comprehensive Psychiatry*, New York, 1979, Nov./Dec., vol. 20, no. 6, pp. 569-578.

This paper discusses the problems involved in the diagnosis and treatment of psychiatric patients in a busy emergency department. The atmosphere of such a department may cause staff to rush interviews with patients who are themselves under stress. Individual staff should be encouraged to seek help from other members of the psychiatric team when undecided about a particular patient. The percentage of severely disturbed individuals, including many with schizophrenic and manic-depressive disorders, has increased recently in emergency departments. Psychiatric emergency room staff must be given the chance to learn about these regressed states and how to deal with them, and the inexperienced should be carefully supervised. Another difficult group of patients are those brought in by police after violent episodes. These patients, often abusive and under the influence of drugs or alcohol, often remain in the department for some hours which allows time for recovery and more accurate evaluation. Some patients present subtle manifestations of mental disorganization and are often at odds with friends and family. Staff must understand the position and encourage patients to express their feelings, so long as injury to staff or the patient is not threatened. When a patient is unco-operative, the therapist must discuss the reasons for hostility before he can establish the rapport needed for therapeutic help.

1019. BLAIR, Emil. **Development of a department of emergency health services in a teaching hospital.** *Israel Journal of Medical Sciences*, Jerusalem, 1980, Feb., vol. 16, no. 2, pp. 138-146.

Emergency health services have evolved as a complex and demanding activity. Factors responsible include public perception and the need for ready access to relatively prompt attention in a highly developed and expensive health resource area, and reliance on these services for clinical material for teaching and research. A logical, comprehensive approach is required to control the development of such a service as an

academic department and to eliminate haphazard, unexploited growth. This paper discusses the following aspects: specific aims; organization and policies; educational programmes (nursing, medical and public); research audit; and dynamics. There are diagrams of an emergency health services system, a departmental organization chart, a peer review system, and flow-graph models of an emergency health service system detailing the hospital subsystem and for designating a central hospital for patient reception.

1020. BLOOMGARDEN, Zachary and SIDEL, Victor W. **Evaluation of utilization of laboratory tests in a hospital emergency room.** *American Journal of Public Health*, Washington, D.C., 1980, May, vol. 70, no. 5, pp. 525-528.

The charts of every fifth adult visit over a three-week period to the emergency room of a 700-bed teaching hospital were reviewed to evaluate the use of laboratory tests with respect to necessity, clinical relevance and medical-legal requirements. A total of 630 laboratory tests and X-ray examinations from 218 patient visits were analyzed. Of these tests, 433 (68 per cent) were classified as necessary for clinical decision-making, an additional 68 (11 per cent) as 'relevant' and four (one per cent) as 'medico-legally required', leaving 125 (20 per cent) classified as 'not indicated'. The number of tests per visit showed a strong negative correlation with the necessity of tests and with the quality of care. Results suggest the usefulness of identifying a subgroup of patients with excessive tests and implementing measures to alter testing behaviour for this subgroup.

1021. VICARY, M. J. **A simulation study of the accident and emergency department at Hull Royal Infirmary.** Hull, University of Hull, Department of Operational Research, 1979. vi, 169pp.

A casualty department is described with particular attention to the arrival patterns of different categories of patient and the medical staffing policy. A computer simulation model has been developed and is used to make recommendations for staffing policies. Figures are also given for proposed paediatric departments, using the same model. To cope with some 200 cases per day six senior house officers (nine if children are treated separately) are required and a proposed rota is shown.

DAY HOSPITALS

See Abstract No. 991

CHILDREN

See also Abstract No. 915

1022. GATISS, Sheila and others. **Children in hospital: a report on the extent to which hospitals have implemented DHSS recommendations since the Platt report.** London, Consumers' Association, 1980. [iii], 144pp. ISBN 0 85202 188 7 £15.00

This report examines how far the recommendations of the 1959 Platt Report on the welfare of children in hospital have been implemented. Three sources of information

were used: (i) a survey of parents whose children had recently been in hospital; (ii) interviews with staff in a sample of hospitals; and (iii) preliminary discussions with children themselves. On the whole, the survey has shown that while great improvements have been made, in some cases beyond the Platt Committee's recommendations, there still remain areas in need of change, for example the unnecessary restricting of visiting hours and the tendency to discourage parents from staying in hospital with their children. An important factor in the treatment of children is the attitude of the staff; the report examines how different attitudes result in differences in care. The role of the parents is also vital. If they had a better idea of the impact of stay in hospital on their children and what they might reasonably expect from the hospital service, they could take steps to bring about change.

1023. HENDRICKX, A.-M. Inschakelen van de ouders bij de opname en begeleiding van hun kind in het ziekenhuis: noodzaak of mythe? **[The need for parent participation during the child's stay in hospital: necessity or myth?]** *Hospitalia*, Brussel, 1979, vol. 23, no. 4, pp. 206-209.

The seventies saw growing understanding of the consequences of a hospital stay for the young child. Separation from the mother can be a traumatic experience, especially if the child is between six months and three years old, since it is too small to understand the reasons for being away from home. A child between three and five may go through four phases of reaction: protest, despair, denial and 'hospitalism'. An enquiry was made in six hospitals among parents of admitted children. On the fifth day of hospitalization or later, the interviewers, who had not previously had contact with the parents, asked how the admission had been experienced, how visiting had been organized, and about visiting rules and contact with the doctors. The parents knew nothing of the interview beforehand, but had the purpose explained and were allowed to be anonymous or to opt out of answering. The importance of parent participation in the care of children in hospital is stressed in the literature and can be facilitated in various ways: extending visiting hours; continuous visiting during the day but not at night; rooming-in etc. Many hospitals still have very restricted visiting hours, although most of the parents asked wanted longer visiting hours, most did not realize the importance of their active participation.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 902, 990, 1039

1024. ARMSTRONG, William A., DRIEVER, Carl W. and HAYS, Robert L. **Analysis of drug-drug interactions in a geriatric population.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1980, March, vol. 37, no. 3, pp. 385-387.

This paper describes the development of a computer programme for screening geriatric patient drug profiles for drug-drug interactions in a pharmacy serving 132 nursing homes. The programme covered 25 categories of drug-drug interactions selected on the following criteria: (i) clinical severity as reported in the literature; (ii) involvement of drugs generally prescribed for geriatric patients; (iii) those reported in the American Pharmaceutical Association's *Evaluations of drug interactions*, second edition; and (iv) those involving drugs listed in the pharmacy's formulary. The programme reviewed

the profiles of 11,173 patients. Of 446 potential interactions reported as clinically significant, 362 had sufficient data to be included in the study. These involved 298 patients (2.7 per cent of the population). Although with preliminary screening, 80.4 per cent of the potential interactions studied would have indicated only a need for close patient monitoring, discontinuation or reduced dosage of at least one of the drugs would have been appropriate for 9.1 and 4.7 per cent respectively.

1025. BLAIR, Kenneth B. **Patient care in long-term care facilities.** *Journal of Long-Term Care Administration*, Washington, D.C., 1980, vol. 8, no. 1, pp. 3-8.

This paper reviews some recent literature dealing with developments in the care of long-stay geriatric patients. It is particularly concerned with: treating the patient as a whole person; preventing the institutionalization of the patient's environment, both physically and socially; remotivating the patient, particularly through the provision of suitable activities; and the need to consider the psychosocial problems of the patients.

1026. BOZIAN, Marguerite W. and CLARK, Helen M. **Counteracting sensory changes in the ageing.** *American Journal of Nursing*, New York, 1980, March, vol. 80, no. 3, pp. 473-476.

A number of specific sensory changes may occur with ageing, but certain nursing measures can help the elderly to adjust to them successfully. These changes cover hearing, vision, depth perception, sense of position, response to temperature, decreased smell and taste, and a decreased touch perception, even of deep pressure. Measures to help hearing include using low tones, not speaking too fast and excluding background noises. Vision may be helped by cleaning spectacles and providing large print books. Depth perception can be improved by leaving wide spaces between items of furniture and using brightly coloured paints. Position sense should be stimulated by exercise, and water and food temperatures checked for those who have difficulty in sensing temperature. Sense of smell can be enhanced by use of colognes and taste by seasoning food well. Those who experience decreased sense of touch should be touched firmly when spoken to and encouraged to buy well-fitting clothes. For the bedridden, change of position is vital. An assessment tool for regular checking of sensory function is described. The data obtained from this can be used to develop a plan of nursing care for each individual.

1027. BURNSIDE, Irene Mortenson, editor. **Psychosocial nursing care of the aged.** 2nd edition. New York, London, McGraw-Hill, 1980. xviii, 346pp. bibliogs. ISBN 0 07 009210 9 £5.35

This book is a collection of papers, all written by nurses. The purpose of the book is to share nurses' thoughts and their experiences with the elderly client as they upgrade the psychosocial care of the aged. The book is divided into five sections: (i) the importance of the initial approach and of communication with the aged person; (ii) the elderly still living at home; (iii) the elderly in the acute care facility; (iv) psychosocial problems in long-term care; and (v) the nursing process and special ueeds of the elderly.

1028. CHALMERS, George Lovie. **Caring for the elderly sick.** Tunbridge Wells, Pitman Medical, 1980. xii, 490pp. ISBN 0 272 79538 0 £14.95

A comprehensive account of modern methods of looking after the elderly is presented. Emphasis is laid on how practical help can be given in a willing and acceptable way. Due regard is paid to the importance of a co-ordination of effort not only in the medical services but in social work, rehabilitation and community services. The value of the contribution made by relatives and the parts played by individual members of the health care team are described, while the use of facilities such as day hospitals and centres are analyzed. Services provided by the social work department and the value of sheltered housing are assessed, as is the caring role of the hospital. The problems of the mentally confused and incontinent are dealt with sympathetically. Practical suggestions are given regarding the effective handling of the elderly disabled and terminally ill, plus an account of the range of services available.

CANCER

See also Abstract No. 1030

1029. KAY, H. E. M. and others. **Cost of bone-marrow transplants in acute myeloid leukaemia.** *Lancet*, London, 1980, May 17, vol. i, pp. 1067-1069.

The Bud Flanagan leukaemia ward at the Royal Marsden Hospital, Sutton, has costed bone marrow transplants in the treatment of acute myeloid leukaemia (AML). The running costs are based on the statutory cost account of the hospital for the year 1978-79, analyzed to produce a cost per patient day. The patients studied are the first 22 in a programme to treat AML by bone marrow grafting during first remission. Most patients spend about six weeks in hospital and the most costly item is nursing the patient in isolation. Medical staffing costs and pharmacy costs vary from patient to patient, but all patients have: (i) a large dose of cyclophosphamide costing £30; (ii) routine prophylaxis for graft-versus-host disease; and (iii) a number of antibiotics. The total drug bill is about £350 for a 44 days stay and each transplant patient costs the central sterile supply department £50 per week. Radiotherapy costs are no more than for the average patient, but clinical pathology costs are. The cost of tissue typing is about £650 per patient. Each patient receives about five units of red cells costing £47.50 and about eight packs of concentrated platelets costing £200. The total cost for a 44 day stay is about £4,464. Patients attend as out-patients weekly for 12 weeks, fortnightly until week 26 and monthly thereafter at a cost of £25 per visit. As 50 to 60 per cent of patients are cured, the case for marrow grafts at £6,000 each is strong.

EAR, NOSE AND THROAT

1030. Patienter med munhålecancer får hemvist på örinkliniken. **[Patients with oral cancer are housed in the ear, nose and throat unit of Caroline Hospital.]** *KS-nytt*, Stockholm, 1980, no. 1, pp. 4-7.

Over two thirds of the patients given surgery for oral cancer have to live without their tongue and portions of the lower jaw, they also lose the ability to speak properly. It is difficult for ward staff to establish contact with the post-operative patient, and

until 1978 patients were frequently referred for psychiatric treatment, with meagre results. Dr. B. Barr, otologist at The Caroline Hospital, established a team to receive the patients prior to radiotherapy and prepare them for subsequent surgery. Each patient's condition and mental state are assessed by the otologist, a social worker, a psychiatrist and a speech therapist, who train him in the techniques and attitudes of mind required after his operation. The patients' reactions to the new team therapy are highly positive: the period of passivity and depression has been replaced by active participation in the learning and therapeutic process. A vital element in the system is the daily ward staff meeting.

CARDIOLOGY

See also Abstract Nos. 1011, 1012

1031. HAMPTON, John. **A change of heart?** *Medeconomics*, London, 1980, May, vol. 1, no. 9, pp. 13-15.

Before heart transplantation is accepted as a routine treatment available on the National Health Service, several matters need to be considered. At the moment, heart transplants lie somewhere between research and service and it would seem sensible to restrict them to two or three centres and provide central research funds for the purpose. The number of patients suitable for a heart transplant will always be limited because: (i) patients aged over 60 do not have the stamina; (ii) there are few patients under 60 with heart disease so severe that transplantation is the only remedy; and (iii) the number of patients with inoperable congenital heart disease will decrease. It is very difficult to calculate the real cost of a heart transplant, especially as it is not yet known how long a successfully transplanted patient will live after the operation. A Department of Health and Social Security circular states that transplants should only be performed in centres where there is already an experienced cardiac team, and calculates the cost of one operation at £17,000, compared with about £2,000 for a valve replacement. Those on waiting lists for valve replacements and pace-maker insertion should take precedence over heart transplants.

ORTHOPAEDICS

See also Abstract No. 928

1032. DEVAS, M. B. **Management in orthopaedics.** *Demonstration Centres in Rehabilitation Newsletter*, Middlesbrough, 1980, April, no. 20, pp. 2-6.

Success in dealing with geriatric orthopaedic patients is dependent on having a proper organization so that all aspects of their care can be dealt with smoothly, efficiently and, above all, quickly. This entails a very high level of management, both of the individual patient and of the unit itself. In the case of elective admissions, careful planning of admission and discharge are vital to the economic use of resources. Emergency patients should be operated upon as soon as possible after admission, followed by early and multidisciplinary assessment. A unit must be cost effective and it is very easy for elderly patients to block beds in a ward if there is not a proper provisional management to enable them either to be sent home or to proper accom-

modation elsewhere. It is particularly important to make sure that all treatment is based on the immediate walking of the patient. Early walking and proper clinical management not only benefit the patient but are financially effective.

UROLOGY

See Abstract No. 937

SURGERY

See Abstract No. 948

MATERNITY

1033. JONES, Paul K., JONES, Susan L. and HALLIDAY, Henry L. **Evaluation of television consultations between a large neonatal care hospital and a community hospital.** *Medical Care*, Philadelphia, Pa., 1980, Jan., vol. 18, no. 1, pp. 110-116.

A collaborative telemedicine project was established between a large regional teaching hospital and a small inner-city community hospital serving a high-risk perinatal population. This paper evaluates the project in terms of the impact of television consultations on the provision of specialized care to infants born of high risk mothers with the aim of reducing infant mortality and morbidity. The system permitted visual and audio communications between the neonatal specialist at the teaching hospital and nurses at the community hospital. Interhospital transfer rates for neonatal intensive care before and after the television link was established were compared. The results suggested that television consultations facilitated the formation of appropriate criteria for interhospital transfer and that routine clinical screening tests were performed more consistently following initiation of interhospital consultations. The project is discussed in the light of six parameters: geographical separation; telecommunication equipment; staffing arrangements; organizational structure; clinical applications; and normative structure.

1034. **Needs and expectations in obstetrics.** *Health Bulletin*, Edinburgh, 1980, May, vol. 38, no. 3, pp. 99-125.

The proceedings of a one-day, multidisciplinary conference arranged by the Scottish Home and Health Department are presented. The aim of the conference was to underline those aspects of obstetric services where expectant mothers and clinicians had differing perceptions of need, and to discuss the scope for fostering a greater awareness among expectant mothers of the potential benefits to them and their unborn children of modern technological facilities. The speakers at the morning session were asked to give their views on the problems currently facing practitioners in meeting the needs of expectant mothers and to draw attention to the areas where service providers and mothers perceived those needs differently. The aim of the afternoon session was to bring to bear the findings of sociological and other research and to consider the way in which planning of services might achieve greater effectiveness and acceptability of obstetric care.

1035. TEW, Marjorie. **Is home a safer place?** *Health and Social Service Journal*, Basingstoke, 1980, May 30, vol. 90, no. 4695, pp. 702-705.

In the belief that delivery in maternity hospitals must be safest, recent British policy has been to provide sufficient facilities for all births to take place there; at the same time facilities in general practitioner maternity units have been greatly contracted and the domiciliary service reduced to a bare minimum. Crude mortality rates have, until recently, been much the highest in hospital, but it has been argued that this excess is because more high risk cases are treated there. Using data from the 1970 survey of British births, it is shown that the excess mortality cannot be explained to more than a small extent by the excess of births at high risk on account of maternal or infant characteristics, nor by the excess of abnormal births which take place in hospital. The explanation must, therefore, lie at the stage of actual birth. It is suggested that it is the fact that interventions of various kinds take place much more often in hospital. A properly conducted randomized controlled trial would be welcome, but if the objective is to reduce perinatal mortality as quickly as possible, all the evidence already accumulated indicates most cogently that the most immediate and effective method would be reversal of the policy which seeks to ensure that all births take place in maternity hospitals.

OPHTHALMOLOGY

1036. ZONDERVAN, S. Over het bestaan en het bestaansrecht van categorale ziekenhuizen. **[On the existence and reason for existence of specialist hospitals.]** *Ziekenhuis*, Utrecht, 1980, May 7, vol. 10, no. 9, pp. 258-262.

Dutch Government policy to close down specialist hospitals or integrate their functions into larger hospitals (26 hospitals are affected) is based on four premises: (i) functions of specialist hospitals should form part of the activities of general hospitals; (ii) general hospitals can provide better co-ordination between various disciplines; (iii) specialist hospitals do not make the most efficient use of expensive equipment, auxiliary services and central provisions; and (iv) management in specialist hospitals lacks flexibility. The author, economic director of the Utrecht Eye Hospital, challenges each of these premises. He argues that: (i) some specialist functions should be carried out in specialist rather than general hospitals where they will be subject to considerations of cost and efficiency in relation to other disciplines; (ii) in general hospitals there may be less scope for research and innovations in specialized fields; (iii) specialist hospitals would attract sufficient volume and variety of patients to justify acquisition of expensive equipment, and statistics show that average cost per hospital day is lower for specialist than for general hospitals; and (iv) specialist hospitals do adapt to changes in demand, such as increased polyclinical treatment, shorter lengths of stay, etc. The author concludes that there is a strong case for maintaining specialist hospitals, which could be leading centres throughout the country, and urges that specialist hospitals should unite in defence of their existence. The paper includes two tables and three photographs.

PSYCHIATRY

See also Abstract No. 1018

1037. BENDERS, H. Niet alleen voor psychologen. **[Not only for psychologists.]** *Ziekenhuis*, Utrecht, 1979, Oct. 17, vol. 9, no. 20, pp. 498-501.

Hospital psychologists are invited to assess the approaches to their activities in hospital work. Should the psychologist in this new field direct his efforts exclusively at the patient with the known methods of investigation and treatment, or should the approach be aimed at the patient in his environment in the hospital? The latter approach suggests that the hospital is part of the community and therefore one should not primarily discuss health care but how society works and how people get on in institutions—especially as people today often feel uncertain and insecure. The author suggests that too much emphasis is placed on science and treatment, and psychologists should restrict their aim to helping people to discover their own identity and relate to other people in the hospital environment.

1038. BENNETT, Douglas. **The chronic psychiatric patient today.** *Journal of the Royal Society of Medicine*, London, 1980, April, vol. 73, no. 4, pp. 301-303.

Despite active treatment and rehabilitation, a number of psychiatric patients have to be cared for in hospital for long periods of time. The possibility of caring for such patients in a 'hospital hostel' or 'hostel ward' is being explored at the Maudsley Hospital, London. Patients are responsible for their own self-care, but in terms of nursing and staffing the hostel functions like a hospital ward. When 14 patients living in the hostel ward were compared with 15 living in a hospital ward, they showed a significant decrease in their rated problems. In many schizophrenic patients there is a need for continued adjustment in treatment, requiring the continuity of care provided by the day treatment setting. In the Camberwell area there is a high use of day hospital and day centre care and less reliance on group homes for long stay patients. However, there is also a need for chronic day hospital places for patients who need frequent re-admission or have a medical problem with which they are unable to cope. The chronic patient needs a combination of services involving day care, community services and a supportive service offering care in the longer term.

1039. BERG, Stig, SVENSSON, Torbjörn and TJELLDEN, Annalena. **Milieu treatment in a ward for psychiatric long-term care.** *Scandinavian Journal of Social Medicine*, Stockholm, 1979, supplementum 14; pp. 163-172.

The purpose of a project in a female long stay ward at the Psychiatric Hospital, Jonkoping, was to improve treatment and ward behaviour by extended co-operation between the different categories of staff. It was expected that better co-operation and communication would lead to greater motivation and job satisfaction, resulting in a positive effect on the treatment of patients and their comfort. Patients in a similar ward were used as a control group. The 33 patients in the experimental ward had a mean age of 74 with a range between 57 and 92; the 23 patients in the control ward had an average age of 74 and a range between 52 and 92. During the first three months of the one-year project, a 15-hour course in gerontology, geriatrics and psychology was held. A staff

group was also initiated and held for one hour a week for a year. A rehabilitation conference was held regularly for four months. After this a group nursing system was introduced. The patients on the experimental ward showed significant improvements in personal hygiene and faecal incontinence. They were also more restless, probably due to their heightened activity. More patients stayed out of their beds in the evening. Staff felt less physical and psychological strain.

1040. Commissie-Van Dijk acht de rechtspositie van psychiatrische patiënten onvoldoende geregeld. **[The Van Dijk Committee considers the legal position of psychiatric patients unsatisfactorily controlled.]** *Ziekenhuis*, Utrecht, 1980, Jan. 23, vol. 20, no. 2, pp. 46-50.

A series of improvements are proposed in the legal status of voluntary and involuntary patients in psychiatric hospitals. They include: (i) the introduction of appeal commissions that will function as Ombudsmen; (ii) the establishment of a special chamber of each regional legal court; and (iii) a more intensive check on the execution of the legal regulations. Each region should have at least one Commission to deal with complaints. Its members should be appointed by the Ministry of Health and Environmental Hygiene and consist of a lawyer chairman, a psychiatrist, a nursing officer, a representative of those asking assistance, and a person genuinely interested in the rights and duties of psychiatric patients. The Commission should sit for five years and be eligible to sit for one further period. The groups should be empowered to deal with complaints and to have an advisory capacity towards the Minister regarding proper care of patients, introduction of patients' councils, legal guardianship, information, and treatment such as irreversible procedures, electro-shock, group therapy, medication and freedom-limiting procedures.

1041. Cook, D. A. G. and Skeldon, I. **The use of a contract admission procedure on an acute psychiatric admission ward.** *British Journal of Psychiatry*, London, 1980, May, vol. 136, pp. 463-468.

In November 1977, a contract admission procedure was introduced in the 24-bed acute admission unit of the 600-bed Glenside Hospital, Bristol. The contract was negotiated at an assessment interview, ideally prior to admission. It was framed in terms of length of stay, aims of the admission and, where appropriate, a traditional treatment programme using physical methods. The 77 patients discharged from the unit between January and June 1978 were compared with the 83 discharged in the same period of the previous year before the contract admission procedure was introduced. The length of stay in hospital was reduced, but preliminary studies suggested that the re-admission rate was not altered significantly. There was no evidence to suggest that shortening the length of stay increased the likelihood of relapse, nor were increased demands made on the day hospital service.

1042. Draper, R. J. **Psychiatric out-patient morbidity at a Dublin general hospital.** *Irish Medical Journal*, Dublin, 1979, Sept. 28, vol. 72, no. 9, pp. 383-389.

The study described was undertaken to examine non-hospital psychiatric morbidity in 300 patients referred to the Royal City of Dublin Hospital during a three-year period. Ages ranged from 10 to 80 years, with a majority of both sexes in the 20 to 34 age

group. Fifty-five per cent of the patients lived near the hospital. Fifty per cent were referred by their general practitioner, 75 per cent requesting treatment and 44 per cent diagnosis. Histories of formal psychiatric treatment were given by 22 per cent, but were a poor guide to current diagnosis. Of 30 patients referred from casualty, 16 complained of anxiety and 62 per cent of 114 patients referred by consultants had a psychogenic explanation for physical symptoms. When a formal psychiatric diagnosis was given, 31 per cent were suffering from psychotic illness and 48 per cent from neurosis and personality disorders. Ten per cent of all referrals suffered from alcoholism. The diagnosis of referring doctors were considered in the psychiatric assessment. The addition of items of psychopathology, such as personality factors, allowed symptoms to be built up into a diagnosis. The study shows that, when psychic stress is being discussed, doctors and patients have an inadequate understanding of each other. This has important implications, both for medical education and the planning of health services.

1043. GOLDSTONE, Leonard A. **The consultants' and doctors' most recent visit to psychiatric hospital long stay in-patients.** [Manchester, University of Manchester Institute of Science and Technology], 1980. [i], 9pp.

This paper reports the results of a survey of the medical case notes of in-patients of a large psychiatric hospital who had two years or more continuous hospitalization. On the survey day, 506 males and 598 females were eligible for consideration and their case notes were studied. The conclusions were: (i) there exists a difference between males and females in the time since a consultant's case note entry, in the case of some females, there had not been an entry for several years; (ii) as the female patients age there is less chance of the case notes containing a recent consultant's entry; and (iii) younger male patients are seen more frequently but there is not, as in the case of females, such a decline in visits to the over 65s.

1044. KATZ, Robert M. **Unit dose packaging for long-term mental health facilities.** *Hospital Pharmacy*, Hagerstown, Md., 1980, Feb., vol. 15, no. 2, pp. 62-67.

Oral, solid, unit dose drugs may be purchased from pharmaceutical manufacturers, packaged locally either by hand or by machine, or prepared by a vendor pre-packaging service, on site or remote. The extent to which a hospital uses one or all of the available means is determined by economic considerations, quality assurance, and convenience. A study to determine the use and cost of providing oral, solid, unit doses was carried out in Belchertown State School and Monson Developmental Center, which together care for 1,400 patients. The results in the two institutions were as follows: (i) 12 and 17 per cent of doses were not commercially available; (ii) 656 and 134 technician hours per year could be saved by using a vendor packaging service; (iii) only five and 15 per cent of the doses were available commercially at little or no additional cost compared with bulk purchase; and (iv) 83 and 63 per cent of the doses were available commercially at a premium price of $34,138 and $8,544 per year. The unusually high quantity of medications not commercially available in unit dose form and the high cost of purchasing those that are available may be the result of the special care provided. Therefore, methods of providing unit dose products in acute general hospitals, where purchase from manufacturers is the primary method, may not be adaptable to mental health and other specialized facilities.

1045. KENSINGTON AND CHELSEA AND WESTMINSTER AREA HEALTH AUTHORITY (TEACHING). SOUTH DISTRICT. **Banstead Hospital: report of working party on reward payments for patients.** (Chairman: M. J. Barsby). [London], Kensington and Chelsea and Westminster Area Health Authority, South District, 1979. [ii], 53pp.

In 1978, a review of the rehabilitation facilities available for patients at Banstead Hospital was undertaken. It revealed that systems for the payment of patients' monies were fragmented and not all functioning in such a way as to provide maximum therapeutic value for patients nor safeguarding staff interests. This led to the decision to set up a Working Party to examine the system and methods at Banstead Hospital. Recommendations put forward include: (i) a common system of reward payment for patients to be provided; (ii) the level of reward payments to be increased to maximum levels without Social Security payments being affected; (iii) all working patients to be eligible for sick pay, paid holiday and a pension on retirement; (iv) the post of Patients' Employment Officer to be introduced; (v) a Job Bureau to be set up; (vi) more information on entitlements to be made available; (vii) working patients to be eligible for leave for training and study; and (viii) loans to be made to patients waiting for Social Security payments.

1046. MOLENAAR, Kees. Hoofdlijnen van organisatieverandering in psychiatrische ziekenhuizen. **[Suggestions for organizational changes in psychiatric hospitals.]** *Ziekenhuis*, Utrecht, 1980, May 7, vol. 10, no. 9, pp. 272, 273.

Increasing responsibilities and involvement of nursing, para-medical and auxiliary staff in treatment of patients, and the general changes in attitude towards the hospital hierarchy call for a system of interdisciplinary co-ordination. This means working as a treatment team with clear agreements in which fields, by whom and on what level decisions are taken. The primary object of all disciplines is treating the patient, which starts in the ward unit at the root level of the organization and where integration of the professional groups should begin. From there, course of action and control in the team should be built up to higher levels, which is a democratic way of formulating the treatment procedure. Team members in individual contact with patients should also present a co-ordinated front. To achieve these changes will take time and require confidence, co-operation between those involved, and good quality planning. Progress towards such changes should be actively pursued and may be started as experimental projects. Rate of progress and improved quality of treatment will depend on their success.

1047. ROBERTSON, G. and GIBBENS, T. C. N. **Transfers from prisons to local psychiatric hospitals under section 72 of the 1959 Mental Health Act.** *British Medical Journal*, London, 1980, May 24, vol. 280, pp. 1263-1266.

The problem of finding places in local psychiatric hospitals for sentenced prisoners who become ill has been given some prominence in recent years. If judged by the criterion of hospital admissions, the Mental Health Act 1959 has not benefited the mentally ill prisoner. During a wider study of mentally abnormal offenders, a fall in the number of section 72 orders was noted and a subsidiary study was undertaken to try to determine whether or not there were any obvious reasons for this. Analysis of a

recent year's intake of section 72 transfer patients suggests that, even when the section operates and a man is transferred to hospital, he is less likely to be criminally experienced and is less likely to have served previous prison sentences than his counterpart during the early years of the Act's operation. As regards diagnostic capacity, about eight out of every 10 men transferred from prison were deemed to be suffering from mental illness, usually schizophrenia; only two per cent were labelled as psychopathically disordered. Possible reasons for the difficulty prison medical officers find in transferring offenders to psychiatric hospitals are discussed and ways of remedying this unsatisfactory situation are considered.

1048. SIMPSON, Ruth. **Psychiatric nursing—what now?** *Nursing Times*, Basingstoke, 1980, June 5, vol. 76, no. 23, pp. 1020, 1021.

The author outlines the attitude to treatment of psychiatric patients since the eighteenth century. The greater use of physical treatments in the first half of the present century had little effect on psychiatric nursing, which remained largely custodial. After the setting up of the National Health Service, candidates were not accepted for the Royal Medico-Psychological Association's examinations and psychiatric nurses took a general as well as a psychiatric training. Formal training schools were set up in psychiatric hospitals. Now that psychosocial therapy rather than physical treatment dominates the psychiatric scene, the pattern of psychiatric nurse training needs to change. The Jay Report on mental handicap nursing and the Tait Report of the Royal College of Psychiatrists have shown that nurses in the psychiatric and mental handicap field are dissatisfied with present training methods and are anxious about future developments.

1049. TEBBET, John. **A creative use of resources.** *Health and Social Service Journal*, Basingstoke, 1980, May 2, vol. 90, no. 4691, pp. 583-586.

The Gloucester Centre, Peterborough, is a relatively small-scale hospital unit for the mentally handicapped. Its social work team consists of a team leader and three social workers (including two part-time staff). Over the last two years the team has supported over 200 families in the community and developed several low-cost community resources. These include: a group home for borderline mentally handicapped persons; an opportunity group for the pre-school mentally handicapped; a welfare rights advisory service; and a short-term family care scheme which has finance and substitute careers to offer short-term relief to parents of mentally handicapped children for the summer of 1980. Other developments include co-ordination and advisory work and the training of social work students.

1050. THOMAS, Derek, KAT, Bernard and MCPHERSON, Frank. **An independent profession.** *Health and Social Service Journal*, Basingstoke, 1980, May 23, vol. 90, no. 4694, pp. 676-678.

The report of the Trethowan Committee in 1977 recognized the independent professional status of clinical psychology, advocated the development of integrated and comprehensive clinical psychology departments serving defined local populations, and chose the Area as the level at which to organize the services. Many Area departments

have been established, together with some district services; but in some parts of the country no real progress has been made. Drawing on their experiences in Northumberland and Tayside, the authors discuss the implications of the proposed simplified regional/district structure for the National Health Service. It is concluded that the reorganization should be used to consolidate and develop the integrated and co-ordinated provision of clinical psychology to a defined geographical population. Organization at district level is the preferred option, but because of the small number of clinical psychologists employed, carefully worked out interdistrict agency agreements will have to be made. There will also be a need for strong professional advisory activity and co-ordination at regional level.

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